Experiences of Sexual and Physical Intimacy from the Voices of African American Female Childhood Sexual Abuse (CSA) Survivors: A Phenomenological Study

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Dedication

Alexander Rhashan Moncrief and Mary Greer, I dedicate this achievement to you. Alexander, my son, I hope you use my journey as a testament to the many possibilities available in life. The journey to greatness may not be easy, but make your dreams and aspirations worth the fight. Mary Greer, grandmom, thank you for your unconditional love and support. I know nothing is impossible with you as my guardian angel.

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Abstract

Experiences of Sexual and Physical Intimacy from the Voices of African American Female Childhood Sexual Abuse (CSA) Survivors: A Phenomenological Study
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African American women currently make up approximately 13% of the female population in the United States (U.S.) (Guerra, 2013), yet 40% of African American women will report they have been coerced into some form of sexual contact before the age of 18 (Women of Color Network, 2006). African American women are also more likely to experience some of the severest forms of childhood sexual abuse (CSA). An experience of CSA can put a significant strain on the ways in which a survivor experiences physical and sexual intimacy with a romantic partner in adulthood. It is necessary to examine how CSA affects physical and sexual intimacy among African American females considering they are most: (a) likely to endure CSA, (b) susceptible to negative effects of CSA, and (c) a relationally injured by historical sexual trauma in the U.S. The purpose of this study is to explore the experience of sexual and physical intimacy in opposite-sex, romantic relationships among African American females who have endured CSA. There were three main themes that emerged from this study: a) CSA does have a negative impact on intimate interactions and behaviors in early adulthood, b) positive experiences of intimacy are possible in the context of a stable and loving relationship after CSA, and c) partner's awareness of the abuse does positively influence how intimacy is received and reciprocate.

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Chapter 1: Statement of the Problem

Marriage was highly prevalent among African American men and women prior to the 20th century (Allen & Olson, 2001). For example, marital statistics from 1890 shows 85% of African American men and 75% of African American women between the ages of 34-44 reportedly were married during this time (U.S. Bureau of Census, 1979). These high rates of marriage continued well into the 20th century. Between the period of 1940–1960 most African American families within the United States (U.S.) were marriage based (Bryant et al., 2010). Since this period of time, marriage has changed drastically within the African American community. Marital rates among African Americans began to take a sharp decline in 1980 (Elliott, Krivickas, Brault & Kreider, 2012). In comparison to other racial and ethnic groups, African Americans currently have the lowest marital rates, highest divorce rates, and highest rates of individuals who have never been married (Chambers & Kravitz, 2011; Tucker & Mitchell-Kernan, 1995). Although marriage is not the sole determination of relationship commitment, these trends are disturbing and reflect a state of crisis among African Americans. The crisis has potential negative consequences for African Americans at both individual and societal levels. Among these negative consequences are: poverty, economic hardship, and social, psychological, and health problems (The National Center on African American Marriage and Parenting, 2011).

Research on marital quality and satisfaction show marriage is in a crisis among African Americans. In comparison to partners from other racial and ethnic groups, African American partners have the poorest rating of marital quality (Bryant et. al., 2010; Brown, Orbuch, Bauermeister, & McKinley, 2013; Bulanda, 2008). Marital satisfaction

also is low among African Americans. Data examining marital happiness among Black and White partners from 1973 to 2006 showed marital happiness was highest among Whites and husbands and lowest among Blacks and females (Corra, Carter, Carter, & Knox, 2009). The low ratings of marital quality and satisfaction show marriage is not stable among African Americans.

Despite current marital trends, African Americans do value and desire marriage (Curran, Utley, & Muraco, 2010; The National Center on African American Marriage and Parenting, 2011). In fact, African Americans may favor marriage and believe in marriage more than partners from other racial and ethnic groups (Saad, 2006). So why then is marriage in a state of crisis within the African American community? In order to understand contemporary relational trends among African Americans, intimacy patterns have to be examined within a historical and structural framework.

Enslavement of Black Men and Women

Slavery in the U.S. changed the nature of marriage and intimate relationships between African American men and women. The relational breakdown between Black (term used to describe enslaved men and women of African descent) men and women may have begun before the first slave ship arrived in Jamestown, Virginia in 1619 (West & Johnson, 2013). During the journey from Africa to America, Black women were raped and impregnated by crew aboard the voyage ships (West & Johnson, 2013). This sexual victimization of Black women continued upon arrival to the U.S. Once Black women arrived in the U.S. they were stripped, placed on auction blocks, and subjected to examination by on-lookers who were trying to determine their value (West & Johnson, 2013).

During slavery, conditions worsened for Black women as rape and sexual assault escalated. It is estimated that 58% of Black women between the ages of 15-30 experienced some form of sexual assault during slavery (West & Johnson, 2013). The end of slave importation in 1808 (West & Johnson, 2013) did not bring any resolve for Black women. In fact, each stage of history following the ban of slave importation has led to more injustice for Black women. The ban on importation of slaves in 1808 led to the establishment of systemic sexual exploitation via slave breeding (forcible sex for the purpose of reproduction between Black men and women) (West & Johnson, 2013). Slave breeding created the dynamic in which Black women were sexually victimized not only by White men, but Black men as well.

During the 1800's there were established rape laws in place. However, rape laws provided protection and justice for White women, not Black women. Unprotected by the laws of society, Black women were subject to rape by White and Black men (West & Johnson, 2013). "Unrapeable" became the grounds for sexual acts of violence committed against Black women. Labeled as promiscuous and hypersexual, Black women were considered incapable of being raped by Black or White men (Donovan & Williams, 2002). This reasoning became the justification for sexual victimization against Black women (Conwill, 2010).

Relationally, slavery sought to destroy the intimate connections between partners by breaking bonds of caring, nurturing, protection, and support (Lawrence-Webb, Littlefield, & Okundaye, 2004). This was done via sexual victimization and marginalization of Black men. On the journey to the U.S. from Africa, Black men were forced to bear witness to the sexual victimization of Black women. Their inability to

intervene and protect their partners caused Black men to look on as helpless bystanders. The unfortunate inability to protect Black women may have been the beginning of the intimate breakdown between Black men and women. Intimate bonds between Black men and women continued to worsen when Black men were forced to join White men in sexually victimizing Black women. Being forcibly victimized by men who shared their history and culture may mark the biggest breakdown of intimacy between Black men and women as trust was severed.

Post Enslavement

The Civil War may have marked the end of slavery in the U.S. (Danzer, 2012), but African Americans still were treated as unwelcomed citizens. The laws of society post enslavement left African Americans stripped of rights that were afforded to White citizens. If enslavement had not occurred in the U.S., relationships (marriage in particular) among African Americans would not be in this current declining state. Poor living conditions (caused by limited access to resources after slavery), difficulties sustaining longevity in relationships (caused by forced partner separation), and struggles establishing/ maintaining intimacy (caused by forced breeding, sexual victimization, and broken trust) are all direct effects of enslavement in the U.S.

The living conditions within the African American community post slavery continued to pull men and women farther apart, damaging the possibility of establishing healthy intimate relationships and marriages. The laws of segregation forced African Americans into impoverished communities, low paying jobs, and poor educational systems (Danzer, 2012). In the aftermath, African American communities were left to endure: high rates of incarceration (Harknett & McLanahan, 2004), poverty, rise in crime,

domestic violence, and drug problems (Danzer, 2012). In addition to financial strain and employment status, Bryant et al. (2010) found racial discrimination and minority stress/strain also are strong explanations for poor marital quality and high rates of divorce among African American partners. All of these things strongly contribute to the declining marital rates among African Americans (Curran et al., 2010).

Sexual Victimization

The ways in which marriage has changed across time for African Americans is most evident among African American women. In 2010, African American women were more likely to be divorced, separated, and single in comparison to men (including African American men) and women from other racial and ethnic groups (U.S. Census Bureau, 2010). Historical, societal, and individual factors are identified as the causes of current marital trends among women in the African American community (Dixon, 2009). Issues Black women experienced during and post slavery offer the greatest explanation for why marital rates have decreased and divorce rates have increased. The sexual victimization of Black women that occurred during and post slavery has made Black women vulnerable to the intimate struggles they endure today (West & Johnson, 2013). The longstanding history of sexual trauma among African American women in the U.S. is often ignored as a contributing factor to these trends. An experience of sexual trauma negatively impacts the ways in which a survivor experiences intimacy (Sinclair & Dowby, 2005), which in turn affects functioning in a romantic relationship or marriage. This may help to explain why African American women report lower relationship satisfaction and quality in comparison to Black men and partners from other racial and

ethnic groups (Bryant, Taylor, Lincoln, Chatters, & Jackson, 2008; Broman, 1993; Brown et al., 2013; Dillaway & Broman, 2001).

African American female survivors of childhood sexual abuse (CSA) may be at most risk for experiencing these marital/relationship trends. Of all youth, CSA is more prevalent among African American females. Today, 1 in 4 African American girls will be sexually abused before the age of 18 (West & Johnson, 2013). These youth are more likely to experience CSA than both males and females of any other racial and ethnic group (U.S. Department of Health and Human Services, 2012). A great deal of adult female survivors of CSA experience high rates of divorce, separation, and singlehood (Pérez-Fuentes et al., 2013; Cherlin, Burton, Hurt, & Purvin, 2004), all of which are already most prevalent among African American women (U.S. Census Bureau, 2010). Understanding the intimacy patterns of CSA survivors within the context of romantic partnerships is vital to understanding marital and relationship trends among African American females. Gathering this knowledge could not only improve marriage between African Americans partners, but it also could improve the functioning of the African American community overall.

Purpose of Study

The purpose of this study was to explore the experience of sexual and physical intimacy in opposite-sex, romantic relationships among African American females who have endured CSA. The research questions that helped to guide this exploration are:

1) How do heterosexual, African American female survivors of CSA experience physical and sexual intimacy in their current romantic relationships?

2) How (if at all) do heterosexual, African American female survivors of CSA believe an experience of CSA has influenced their experience(s) of physical and sexual intimacy?
3) In what way(s) do African American female survivors of CSA believe their current partners have influenced their experiences of physical and sexual intimacy?

Below are the definitions of physical and sexual intimacy that were used to guide this study.

Physical intimacy is created through touch. Any form of touch that is intended to arouse feelings of love in the giver and/or recipient generates physical intimacy (Gulledge, Gulledge, & Stahmannn, 2003). Behaviors that create physical intimacy between partners include: backrubs/massages, caressing/stroking, cuddling/holding, holding hands, kissing on the lips, and kissing on the face (Gulledge et al., 2003).

For the purposes of this study, sexual intimacy is "sharing loving experiences, physical touch and intercourse and as a whole those relationships planned for sexual excitement arousal and satisfaction" (Botlani, Shahsiah, Padash, Ahmadi, & Bahrami, 2012, p. 377). Sexual intimacy allows partners to connect interpersonally and express their mutual passion for one another (Theiss & Nagy, 2010).

Phenomenology

Phenomenology takes the lived experiences of individuals and reduce it into a description that is reflective of how the individuals see things from their point of view (Creswell, 2007; Omery, 1983). The utilization of this research method assisted the researcher with the goal of allowing African American women survivors of CSA to tell

their stories of physical and sexual intimacy from their own experiences. It was hopefully a source of empowerment and strength as they shared the experiences that often are kept private. The decision to conduct the research with African American women grew from the researcher's location as an African American woman and the dearth of scholarly literature emphasizing stories/voices among this group of CSA survivors. The researcher hopes to use this study to acknowledge and highlight the experiences of African American CSA survivors and contribute to the couple and family therapy literature on African American relationships.

Overview of Theoretical Frameworks Guiding this Study

An exploration into the ways in which African American women experience physical and sexual intimacy after enduring CSA was best examined through the constructs of Black Feminist Thought (BFT) and Womanism. These constructs are most applicable for this exploration due to their focus on: (a) understanding how interlocking systems impact the functioning of African American women, (b) gathering understandings from the perspective of African American women, and (c) empowerment of African American women. The process of understanding how this group of African American women (CSA survivors) experience physical and sexual intimacy after CSA will require more than exploring the entities of CSA and physical and sexual intimacy with these women. It will require taking the time to understand how race-related factors (marginalization, oppression, injustice, and historical sexual trauma), CSA, and physical and sexual intimacy patterns within committed, romantic relationships interplay in their lives. Hence these constructs are deemed best suited to understand these phenomena among this group of women. Most importantly, utilization of BFT and womanism will

help to give voice to a population that is silenced the most, yet most victimized and impacted by CSA.

Chapter 2: Literature Review

Childhood Sexual Abuse (CSA)

What is CSA?

Childhood sexual abuse (CSA) is one of the most horrendous forms of trauma an individual can experience in her/his lifetime. This trauma violates the sacredness and privacy of the body making it no longer feel like a safe place (Lev-Wiesel, 2008). The physical trauma of CSA occurs in childhood, but the effects of the abuse can be long term. Following the experience of CSA, many individuals experience emotional, psychological, and physical devastation (Townsend, 2013) that could possibly last a lifetime. A vast amount of research has been conducted on CSA; thus awareness of the trauma is widespread. Despite widespread knowledge, CSA continues to be an ongoing epidemic in the United States (U.S.). CSA continues to be a problem in the U.S. due to: (a) delays with disclosure, (b) secrecy surrounding the trauma, (c) inability to detect the abuse because visible marks are not left, and (d) inability to gather accurate accounts of abuse from children with under developed cognition and language (Townsend, 2013; Wurtelle, 2009).

Another problem contributing to this ongoing issue in the U.S. is inconsistent definitions of CSA. There is currently no universal definition of CSA and definitions often vary depending on the context in which the matter is being discussed (Townsend, 2013). According to the U.S. Department of Health and Human Services (1993), definitions of CSA can be divided into two categories: legal and clinical. Legal definitions are less descriptive about behaviors/actions that constitute CSA but more specific about the laws that address the crime; clinical definitions focus more on the

behaviors/actions and less on how laws respond to CSA (U.S. Department of Health and Human Services, 1993). Clinical definitions are more suitable for literature, research, and laypersons as they are descriptive about the behaviors/actions that describe CSA. These definitions provide information about: (a) age ranges used to classify CSA, (b) description of behaviors/actions that constitute CSA, and (c) specification of the type of relationship that is labeled CSA (Townsend & Rheingold, 2013). For example, the organization *Prevent Child Abuse in America* (n.d.) defines CSA as:

> "Sexual abuse of a child is inappropriately exposing or subjecting the child to sexual contact, activity, or behavior. Sexual abuse includes oral, anal, genital, buttock, and breast contact. It also includes the use of objects for vaginal or anal penetration, fondling, or sexual stimulation. This sexual activity may be with a boy or a girl and is done for the benefit of the offender. In addition, exploitation of a child for pornographic purposes, making a child available to others as a child prostitute, and stimulating a child with inappropriate solicitation, exhibitionism, and erotic material are also forms of sexual abuse" (p. 1).

This expansive definition draws a complete picture of CSA by highlighting how boys and girls endure CSA and how touch versus non-touch behaviors/actions can constitute CSA. Finkelhor (2009) provides the most comprehensive definition of CSA to date by: (a) providing an exact age range for CSA (up to age 17) and (b) explaining how perpetrators can be familial and non-familial. The nature of the relationship between the victim and perpetrator is an important part of understanding CSA. Intrafamilial CSA is any unwanted sexual contact between a child and an immediate or extended family member

(Seltmann, & Wright, 2013). Commonly known as incest, intrafamilial CSA is a subcategory of CSA.

Statistics/Prevalence Rates

There are currently no accurate estimates of CSA prevalence rates in the U.S. The statistics gathered through research and reporting agencies help create a general idea of prevalence rates, but they do not provide a complete picture. The inaccuracy of prevalence rates is caused by complications with obtaining precise statistics of the abuse. Factors such as: (a) underreporting (lack of reporting), (b) lack of uniformity among CSA definitions, and (c) inconsistent reporting of the abuse ("Childhood Sexual Abuse Statistics," 2012; Douglas & Finkelor, 2005; Wurtele, 2009) make gathering accurate statistics extremely difficult.

Underreporting has a huge influence on CSA prevalence rates. There is a great deal of stigma and shame attached to CSA which would explain why the abuse often goes unreported. CSA is often handled behind closed doors, which prevents proper documentation of the abuse. As described earlier, definitions of CSA can be quite diverse. A lack of uniformity among definitions negatively impacts reporting of CSA. The variety creates confusion surrounding what is CSA versus what is not CSA. For example, definitions that exclude the possibility of youth being perpetrators of abuse do not capture the statistics of youth on youth abuse. This causes CSA of this type to appear nonexistent. Inconsistent reporting also has negative ramifications on data collection of CSA. The process of selecting when to report CSA leads to inconsistent reporting. Selective reporting not only throws off accurate gathering of data, but it also could lead to a lack of perpetrator prosecution and justice for victims. Considering the difficulty with

gathering statistics, current rates most likely underestimate the prevalence of this trauma. Despite the challenges with gathering accurate statistics and prevalence rates, data that helps to give insight into this trauma is available. Through an analysis of CSA studies, Townsend (2013) estimates the prevalence rate of CSA to be at approximately 7.5% in the U.S.

In 2012, approximately 62,936 youth in the U.S. endured sexual abuse (U.S. Department of Health and Human Services, 2013), which is an increase from the 61,472 cases documented in 2011 (U.S. Department of Health and Human Services, 2012). This rate of increase within a year's time shows CSA continues to be a growing epidemic in the U.S. It is estimated that 1 in 10 youth will be sexually abused before they turn 18 years old and approximately 400,000 babies will endure CSA before the age of 18 (Townsend & Rheingold, 2013). While all youth are vulnerable to experiencing CSA, some youth are more at risk than others. Of the 62,936 children who experienced CSA in 2012, girls, youth between the ages of 12 and 17, and minorities (non-White youth) made up the greatest population of victims (U.S. Department of Health and Human Services, 2013).

Both male and female youth experience CSA, but data shows rates for females supersede those of males (Dong, Anda, Dube, Giles, & Felitti, 2003; Finkelhor, Hotaling, Lewis, & Smith, 1990). This insinuates that female youth are more vulnerable to CSA than male youth. It is estimated that 1 in 7 girls will experience CSA before the age of 18 in comparison to 1 in 25 for males (Townsend & Rheingold, 2013). So why are females more susceptible to experiencing CSA than males? Some argue traditional expectations of females as subordinate and submissive to males may explain why females are more at

risk for experiencing CSA (Browne & Finkelhor, 1986; Solomon, 1992). Traditional expectations of subordination put females in a place of vulnerability and risk as they cause a power imbalance between the genders. They create a dynamic in which females are perceived to be inferior and less powerful than males. These views lay the groundwork for beliefs that males are allowed to exert power over females and commit crimes such as CSA.

Of all age groups, youth between the ages of 12–17 are most at risk for experiencing CSA (U.S. Department of Health and Human Services, 2013). It is unknown as to why youth between these ages are most at risk for CSA. The process of maturation during this time frame may be a possible contributor. Between early and late adolescence, youth make their journey through puberty, which causes hormonal and bodily changes (Chulani & Gordon, 2014).

These changes not only prepare youth for adulthood, but they possibly draw the attention of perpetrators, which leads to CSA. The fact that youth between the ages of 12–17 are most at risk for experiencing any form of sexual trauma (not just CSA), provides some level of support for the influence of pubescent changes (Snyder, 2000).

Social economic status (SES) (combination of income, education, and occupation) is the class one occupies in society (American Psychological Association, 2014). SES is often a good predictor of the life experiences one will encounter, including exposure to abuse. It has been shown that youth from low SES neighborhoods are 3 times more likely to endure any form of abuse than youth from a higher SES (U.S. Department of Health and Human Services, 2010). CSA is one form of abuse that is most prevalent among youth from low SES neighborhoods. Among the risk factors for CSA, low SES

has been identified as one of the common factors among youth who have experienced this abuse (Crouch, Hanson, Saunders, Kilpatrick & Resnick, 2000; Douglas & Finelhor, 2005). The relationship between SES status and CSA has been shown in several studies. In examining the relationship between geographic location and CSA, Pérez-Fuentes et al. (2013) found inner city youth are 75% more likely to experience CSA than those who do not live in the city. While not all inner city youth have a low SES, it is likely that a low SES is more common than not. Research with adult CSA survivors also lends support for this possible connection. Swanston et al. (2003) found CSA survivors were more likely to have a low SES in comparison to individuals who had not been abused. As many of the participants were around the 18–19 range, it may be safe to assume their current SES was the same during their youth. According to Russell (as cited in Wyatt, 1990), youth from low SES also are more likely to endure some of the severest forms of abuse, which most likely includes CSA. It has been suggested that things such as exposure to other forms of abuse, environmental crime and violence, limited educational and financial resources, and unemployment are factors that increase vulnerability for CSA (Douglas & Finkelhor, 2005; Lesniak, 1993).

In 2011, child maltreatment (abuse, neglect, and maltreatment) rates for minority youth in many states were greater than the population of youth that resided in the state (U.S. Department of Health and Human Services, 2013b). Essentially, abuse among minority youth is so high that their rates of victimization supersede the number of actual youth in the population. Compared to White youth, minority youth are more likely to experience neglect, physical and sexual abuse, and psychological maltreatment (U.S. Department of Health and Human Services, 2013a; U.S. Department of Health and

Human Services, 2012). During the process of analyzing maltreatment across different races and ethnicities, it is important to understand documented cases of victimization do not necessarily show the frequency in which maltreatment occurs. The reported cases of maltreatment were highest for White youth in 2012, yet the rate in which maltreatment occurred across all youth was highest for African American youth (U.S. Department of Health and Human Services, 2013a). So, how is this information to be understood? White youth make up the largest youth population in the U.S. (Federal Interagency Forum on Child and Family Statistics, 2015), which would explain why cases of maltreatment occur more frequently among this group. The population of African American youth is less than that of White youth yet maltreatment rates are higher for African American youth. Even with rates of victimization dropping, rates of abuse for African American and Hispanic youth continue to be high (U.S. Department of Health and Human Services, 2010). Considering this information, it is not surprising that rates of CSA also are high among African American youth. Victims of CSA are more likely to be African American and Native American youth (Kalof, 2000; U.S. Department of Health and Human Services, Administration for Children and Families, 2012; U.S. Department of Health and Human Services, Administration for Children and Families, 2013a; Pérez-Fuentes et al., 2013).

Effects of Childhood Sexual Abuse (CSA)

Psychological /Substance/ Mental Abuse and Sexuality

It is estimated that 75% of all youth who experience CSA will be harmed to the point of traumatization (Townsend, 2013). This traumatization will likely extend beyond childhood and well into adulthood. Of the approximately 42 million survivors of CSA

living in the U.S. (Townsend & Rheingold, 2013), it is likely that a great deal of them will experience negative effects that cause disruption in their lives. Finkelhor and Browne (1985) explain why CSA leads to negative effects in adulthood through their traumatization framework, which includes four traumagenic dynamics: (a) trauma sexualization, (b) betrayal, (c) powerlessness, and (d) stigmatization. Trauma sexualization is the process in which a child's sexuality develops inappropriately due to her/his experience of the abuse (Finkelhor & Browne, 1985). An experience of CSA causes youth to skip normal stages of sexuality development, which could lead to confusion surrounding sexuality. The ability to trust other individuals is impacted by CSA. An experience of CSA causes a breakdown in trust and eventually leads to feelings of betrayal. The experience of betrayal at a young age creates difficulty in establishing trusting relationships in adulthood. It is likely that every individual who has endured CSA felt powerlessness at some point. CSA violates the most sacred entity, the body (Wiesel-Lev, 2008) and strips youth of their power over their body rendering them powerless. While CSA is a widely known form of abuse, it is possibly one of the most hidden forms of abuse. As sexual engagements and acts are not acceptable between youth and adults in the U.S., CSA is heavily stigmatized in this country. Stigmatization is caused by feelings of shame surrounding the experience. The feelings of shame can be created by the perpetrator or the realization that the actions are unacceptable in society (e.g., religion) (Finkelhor & Browne, 1985).

CSA impacts individuals in different ways so negative consequences of the trauma can look different for each survivor. These consequences could have immediate, short term, or long term effects (Kenny & McEachern, 2000; Wyatt, 1990). Immediate

effects are those that occur after the initial abuse, short-term effects arise in the months following the abuse, and long-term effects could take years to come to the horizon. The extent and length of the negative effects in adulthood depend on: (a) severity of the abuse, (b) duration of the abuse, and (c) relationship between the abuser and abused (Dong et al., 2003). Considering the nature of CSA is a precursor for the extent and length of negative effects, it stands to reason that severe abuse causes the greatest negative effects. Abuse is considered severe when it is: (a) perpetrated by a family member (incest) or close acquaintance, (b) endured at a young age, and (c) long standing and involving penetration (Courtois, 2000; Gold, Hughes, & Swingle, 1996). It is likely that every individual who endures CSA will experience negative consequences in some form during adulthood. Briere and Runtz (1988) argue symptomology becomes greater in later life for anyone who has endured abuse in childhood. The life disruptions that CSA survivors could endure in adulthood vary. Research has shown that exposure to CSA can negatively impact: physical health (Dong et al., 2003; Felitti et al.,1998; Kendall-Tackett, 2002; Wilson, 2010), mental/psychological health (Briere & Runtz, 1988; Browne & Finkelor, 1986; Clark et al., 2012; Fergusson, Boden & Horwood, 2008; Hood and Carter, 2008; Molnar, Buka, & Kessler, 2001; Pérez-Fuentes et al., 2013), and sexual health and sexuality (Senn, Carey, Vanable, Coury-Doniger, & Urban, 2006, Watson, Robinson, Dispenza & Nazari, 2012; Wilsnack, Vogeltanz, Klassen, & Harris 1997).

Individuals who experience CSA are at greater risk for developing health problems in adulthood in comparison to individuals who have not experienced any form of abuse (Sachs-Ericson, Blazer, Plant, & Arnow, 2005; Sachs-Ericsson, Hernandez, & Kendall-Tackett, 2009). The explanation for why CSA predisposes survivors to health

problems has been of great debate. Kendall-Tackett (2002) describes how childhood abuse increases risk for things such as: "depression and post-traumatic stress disorder, participating in harmful activities, having difficulties in relationships, and having negative beliefs and attitudes toward others which in turn increases chances of developing a health problem" (p. 715). The Adverse Childhood Experiences (ACE) study is perhaps the most popular investigation into the relationship between CSA and physical health in adulthood. The results of the study were astonishing as researchers were able to show links between exposure to abuse (physical, emotional, and/or sexual), household dysfunction in childhood, and health problems in later life. Health problems such as: ischemic heart disease, cancer, chronic bronchitis, emphysema, history of hepatitis or jaundice, skeletal fractures, and poor self-rated health were most prevalent among survivors of abuse and possibilities of having a health problem increased as the exposure to abuse and dysfunction increased (Felitti, et al. 1998). Since this study, other research has emerged showing this parallel between CSA and health problems in adulthood. Other health issues that have been associated with CSA include: chronic pain, (Kendall-Tackett, 2001), miscarriages and stillbirths (Thompson, Arias, Basile, & Desai, 2002), cardiovascular disease (Suglia, Clark, Boynton-Jarrett, Kressin, & Koenen, 2014), HIV (Wyatt, Myers, Loeb, 2004; Gielen, Ghandour, Burke, McDonnell, & O'Campo, 2007; Maman, Campbell, Sweat, & Gielen, 2000), and other conditions that impact ability to function (e.g., insomnia, fatigue, stress, etc.) (Wilson, 2010).

The development of a mental health disorder in adulthood is plausible after any form of childhood abuse (physical, sexual, emotional, psychological), but it is especially salient among individuals who have experienced CSA. Survivors of CSA are 2.4 times

more likely to experience mental illness than individuals who have not experienced CSA (Fergusson, Boden & Horwood, 2008) and it is predicted that almost every survivor will endure a psychiatric disorder at some point in their lifetime (Pérez-Fuentes et al., 2013). The ways in which CSA impacts the mental health of a survivor varies from person to person. Two things that increase risk for mental illness are: timing and the nature of the abuse.

The mental health disorders that arise among survivors range across the spectrum. In their comparison study between CSA survivors and a nonclinical sample, Briere and Runtz (1988) found women who experienced CSA were more likely to experience acute and chronic dissociation, somatization, anxiety, and depression. Fergusson, Boden & Horwood, (2008) found significant associations between major depression, anxiety, conduct/antisocial personality disorder, substance dependence, suicidal ideation, and suicidal behavior in their 25-year longitudinal study with survivors of abuse (sexual and physical abuse). In addition to experiencing a mental health disorder, some survivors either contemplate suicide or complete suicide. Suicidal attempts and suicidal ideation are common behaviors among adult survivors of CSA (Clark et al., 2012; Fergusson, Boden & Horwood, 2008; Pérez-Fuentes et al., 2013). In a comparison study, Pérez-Fuentes et al., (2013) found women who experienced CSA were 4 times more likely to inflict self-harm (e.g., self- mutilation and suicide attempt) than women who had not been abused.

Sadly, many survivors of CSA endure further physical, sexual, and emotional abuse in adulthood, which continues the cycle of abuse for them (Rhodes, Ebert, & Meyers, 1993; Arata & Lindman, 2002). This continuation of abuse in adulthood is

known as revictimization. Noll, Horowitz, Bonanno, Trickett, & Putnam (2003) define revictimization as "harm perpetrated by an outside source that serves as an enactment of the initial abuse," (pp. 1453-1454). Women who have experienced CSA are 2 times more likely to experience both sexual and physical revictimization than women who have not been abused in childhood (Barnes, Noll, Putnam, & Trickett, 2009). Cherlin, Burton, Hurt and Purvin (2004) propose that weak, permeable relationship boundaries and incidents of undiagnosed mental illness among women who have endured CSA may explain susceptibility to revictimization.

Anger, fear, sadness, betrayal, and unworthiness are all potential feelings that can arise after an experience of CSA. Coping with these feelings can present as a challenge for many survivors. An inability to cope with these feelings can lead to engagement in behaviors that put their health at risk (Sachs-Ericsson et al., 2009). Risky behaviors are actions that put one's health in jeopardy. The behaviors that put health at risk include: drug and alcohol usage/abuse (Thompson et al., 2002; Wilsnack et al., 1997) and unsafe sexual behavior and practices (Dube et al., 2005).

It is clear that physical, mental, and psychological health is greatly impacted by CSA. Another area that is affected by CSA is sexuality. The organization Advocates for Youth (2007) argue that sexuality is made up of five components: sexual intimacy, sensuality, sexual identity, reproduction and sexual health, and sexualization. Through these five components we are able to: (a) develop a sexual understanding of ourselves, (b) create a sexual profile of ourselves, and (c) establish how we want to intimately and sexually engage with others. CSA creates a great deal of confusion and complication for youth during the development of sexuality. It prevents youth from having a healthy

introduction to sexuality. Instead, youth are forced to experience sexuality in a way that over stimulates them psychologically and physically (Courtois, 2000). Consequently, CSA survivors may engage in risky sexual behavior (Centers for Disease Control and Prevention [CDC], 2014; National Institute of Mental Health [NIMH], 2010). Research has found that CSA survivors are likely to engage in risky behaviors such as: unprotected sex, exchanging sex for objects (e.g., money), and having multiple sex partners (CDC, 2014; Senn et al., 2006). In their examination of HIV risk among a community of women, Johnson, Cottler, Abdulla and O'Leary (2011) found those with a history of sexual trauma were likely to have a history of: substance abuse, sex trading, sexually transmitted diseases (STDs), and multiple sexual partners. These actions are extremely dangerous as they create consequences that can have long-term effects on physical and sexual health. The contraction of a STD or HIV/AIDS is perhaps the most dangerous consequence of all. Women living in the U.S. with a history of CSA have a 1 in 2 chance of contracting HIV (NIMH, 2010).

The Sexual Script Theory proposed by Simon and Gagnon offers a possible explanation as to why risky sexual behavior is prevalent among CSA survivors. According to Sexual Script Theory, "sexuality is learned from culturally available messages that define what 'counts' as sex, how to recognize sexual situations, and what to do in sexual encounters" (Frith, & Kitzinger, 2001, p.210). CSA has the potential to transmit inaccurate and inappropriate interpretations of sex and sexuality, leading to confusion about how to operate sexually.

Interpersonal/Intimate Effects of CSA

CSA has direct consequences for the survivor, but the negative effects of CSA often extend beyond the survivor. The aftermath of CSA has been proven to affect the relationships adult survivors share with: family members (Baker, Tanis & Rice, 2001; Jones & Morris, 2007; Voorpostel, van der Lippe, & Flap, 2012), children (Barrett, 2009; Browne & Finkelhor, 1986; DiLillo, Tremblay, & Peterson, 2000; Fitzgerald, Shipman, Jackson, McMahon, & Hanley, 2005; Kwako, Noll, Putman, & Trickett, 2010; Roberts, O'Connor, Dunn, & Golding, 2004; Seltmann & Wright, 2013), and romantic partners (Colman & Widom, 2004; Lamoureux, Palmieri, Jackson, & Hobfoll, 2012; Mullen, Martin, Anderson, Romans, & Herbison, 1994; Davis, Petretic-Jackson, & Ting, 2001; Pistorello & Follette, 1998). While it is possible that male and female survivors alike experience interpersonal issues following their abuse, research has largely examined how CSA impacts the interpersonal relationships of women.

CSA alters the entire functioning of a familial system (Baker et al., 2001). Similar to a puzzle, CSA scrambles up a family and leaves everyone to rebuild after the trauma. The intimate nature in which CSA violates an individual definitely causes physical forms of intimacy in familial relationships to change. Jones & Morris (2007) argue, "CSA can change marital relationships, parenting styles, and relationships between the victim and siblings, grandparents, aunts and uncles as the meaning of sex and touch has been changed" (p. 10). Physical forms of affection have the potential to be constant reminders of the abuse for all family members, especially the victim. In childhood, CSA leaves everyone unable to experience physical intimacy in the same manner they had before the abuse was disclosed. Things can become progressively worse in adulthood for survivors

as unresolved emotional and psychological distress can cause feelings of distance, unsupportiveness, and strain in familial relationships (Voorpostel et al., 2012). However, familial support following disclosure can help reduce or eliminate this from becoming the case. Familial support following disclosure of CSA is by far the most important factor during recovery from the trauma (Deblinger, Lippmann, Steer, 1999; Elliott & Carnes, 2001) as it helps with the healing process by promoting closeness, bonding, and nurturance (The National Child Traumatic Stress Network, 2011).

The relationship between parent and child is a sacred relationship filled with endless warmth and love. This dynamic between parent and child creates an unbreakable bond and attachment that could last a lifetime. However, an experience of CSA could put the relationship between parent and child in jeopardy. CSA disrupts a survivor's process of attachment and bonding in childhood, leaving some without a strong attachment and bond to their parents. Due to these issues in early childhood, disruption with parenting has the potential to rise in adulthood for survivors and mothers in particular. Female survivors tend to have difficulty with responding to children's needs (Browne & Finkelhor, 1986), establishing a secure attachment/ bond with children (Kwako, Noll, Putman & Trickett, 2010), and setting boundaries for children (Seltman & Wright, 2013). CSA also plays a role in how mothers discipline their children. Barrett (2009) found women who experienced CSA were more likely to use psychological aggression and corporal punishment in their parenting as compared to women who did not have an experience of CSA. The severity of the abuse also plays a factor in how CSA impacts later ability to parent.

The relationship between CSA and interpersonal functioning in adult romantic relationships has been examined for years. It is well noted that an experience of CSA has some impact on the overall interpersonal functioning of a romantic relationship, especially for female survivors (Colman & Widom, 2004; Davis et al. 2001; Pistorello & Follette, 1998). In comparison to women who have not experienced abuse, survivors experience less relational satisfaction, poorer communication, relational discord, and struggles with intimacy in their relationships (Bacon & Lein, 1996; DiLillo & Long, 1999; Roberts et al., 2004). These interpersonal issues may explain why female survivors have difficulties maintaining partnerships for a long period of time. Women who have experienced abuse are more likely to be divorced or separated in comparison to women who have not endured abuse in their lifetime (Pérez-Fuentes et al., 2013). Finding similar results, Cherlin et al. (2004) found women who have experienced CSA are less likely to have long term relationships and stable marriages and more likely to have relationships that last a short span of time.

There are three possible contributors to the difficulties survivors face in partnerships: inability to trust, unresolved issues, and fear of intimacy. A lack of trust plays a critical role in the difficulty some survivors have in their romantic relationships with partners. As CSA breaks trust in childhood, many survivors struggle with establishing and maintaining trust (Bacom & Lein, 1996; DiLillo, 2001; DiLillo & Long, 1999), leaving them unable to develop secure relationships with partners. Lamoureux et al. (2012) labeled unresolved psychological distress (e.g., PTSD and depression) and lowered resiliency (self-esteem and self-efficacy) as the reasons female survivors experience adversity in their romantic partnerships. An experience of psychological

distress and inability to see one's own self-worth/strength create barriers between survivors and partners.

At some point, interpersonal dysfunction does lead to problems with intimacy and sexual functioning in intimate partnerships (DiLillo, 2001). It is believed that partners with similar intimate needs are more compatible and well functioning than those with different needs (Prager, 2003). Women who have experienced CSA have difficulty being intimately in sync with their partners (Davis & Petretic-Jackson, 2000; Pistorello & Follette, 1998). CSA could not only negatively affect how survivors display intimacy, but also could leave survivors unable to intimately connect with partners. Difficulties have been found in the ways in which sexual trauma survivors experience sex, physical pleasure, and intimacy with partners (Maltz, 2012).

Impact of CSA on Physical and Sexual Intimacy

Touch during physical and sexual intimacy between intimate partners can be a signal of warmth and love, which are important components of intimacy (Pisano, 1986). It lets each participant know the experience is equally enjoyed and satisfying. The touch a child experiences during CSA does not create physical and sexual intimacy or feelings associated with healthy physical and sexual intimacy. Major (as cited in Pisano, 1986) highlights the importance of understanding the context and relationship between individuals when it comes to touch as some forms of touch can be used for dominance and power. The touch a child experiences during CSA is done solely for the purposes of dominance, control, and power during an act committed without the child's consent.

An experience of CSA can put a significant strain on the ways in which a survivor experiences physical and sexual intimacy with a romantic partner in adulthood. As stated

by Maltz (2002) “sexual abuse robs the survivor of basic human rights to have sexual experiences unfold at developmentally appropriate times, be of their own choosing, and remain under their own control” (p. 322). The ways in which CSA can impact sexual intimacy and intimate behaviors is on a continuum. On one end, survivors can become over sexualized and promiscuous which leads to risky sexual behaviors such as high-risk sex and prostitution (Maltz, 2002; Sanderson, 2006). On the other end, survivors can become withdrawn from intimacy and intimate engagements leading to no partnerships or the destruction of partnerships. In the middle you have those who may be in partnerships, but struggle with establishing and maintaining physical and sexual intimacy. While the location on the spectrum differs for female survivors, effects of CSA most certainly will come out at some point during the creation of physical and sexual intimacy with a partner. According to Maltz (2012), many sexual abuse survivors will experience: (a) difficulty with arousal and feeling sensation, (b) negative feelings about touch (e.g., anger, guilt, disgust), (c) fear or show no interest in sex, and (d) difficulty establishing and maintaining an intimate relationship. All of these issues are core ingredients of physical and sexual intimacy. Disruption in these areas makes experiencing healthy physical and sexual intimacy a challenge for female survivors of CSA.

Childhood Sexual Abuse (CSA) and African American Women

African American Female Youth and CSA

If all risk factors are combined (gender, SES, and racial identity), one group stands out as most vulnerable for CSA: African American female youth, especially those from a low SES. CSA is highly prevalent in the African American community, especially among African American female youth (Amodeo, Griffin, Fassler, Clay, &

Ellis, 2006; Kenny & McEachern, 2000; Pérez-Fuentes et al., 2013). In 2012, African American female youth made up 26% of U.S. female population (U.S. Census, 2012), yet they experienced CSA more than any other youth group in that year (U.S. Department of Health and Human Services, 2012). This data demonstrates that African American female youth are most susceptible to CSA amongst all youth, yet current CSA rates may not capture the true risk of CSA in this population. As a result, African American female youth continue to endure CSA, which leads to long-term effects that have the ability to greatly impact their overall functioning.

Prevalence Rates of CSA among African American Women

African American women currently make up approximately 13% of the female population in the U.S. (Guerra, 2013), yet 40% of African American women will report they have been coerced into some form of sexual contact before the age of 18 (Women of Color Network, 2006). CSA will most likely be one form of sexual coercion. Data from youth victims (U.S. Department of Health and Human Services, 2012) and retrospective studies with survivors (Perez-Fuentes et al., 2013; Young, Harford, Kinder & Savell, 2007; Ullman & Filipas, 2005; Urquiza & Goodlin-Jones, 1994; Senn et. al, 2006) show CSA is most prevalent among African American women. In comparison to White women, who have the highest population of women in the U.S., African American women are 1.75 times more likely to experience CSA in their lifetime (Amodeo et al., 2006). African American women also are more likely to experience some of the severest forms of CSA. They are more likely to endure: (a) intrafamilial abuse, (b) penetration during abuse, and (c) abuse in their homes and communities in comparison to other female survivors (Wyatt, 1985; Wyatt, 1990; Lestrade, Talbot, Ward, & Cort, 2013;

Amodeo et al., 2006; West, 2002). According to researchers (Ullman & Filipas, 2005; Wyatt, 1990; Briere, & Runtz, 1988), CSA that involves intrafamilial abuse, penetration, and abuse in one's living environment are the severest forms of CSA (Courtois, 2000; Gold, Hughes, & Swingle, 1996).

Despite the abundance of data supporting African American women's vulnerability for enduring CSA, some research claims that these women are not at most risk. Some argue there are no differences among CSA prevalence rates for women and risk for exposure to the trauma is equal for women across all racial and ethnic groups (Clark et al., 2012; Arroyo, Simpson, Aragon, 1997; Wyatt, 1985; Wyatt, 1999; Roosa, Reinholtz, & Angelini, 1999). Possible contributors to these findings are the exclusion of race and ethnicity in discussion of prevalence rates and vulnerability. This was the conclusion drawn by Putnam (2003) who identified race and ethnicity as secondary factors in the discussion of risk for CSA. Despite beliefs, race and ethnicity are included as factors in some studies of CSA and arguments vary about which racial or ethnic group of women are at most risk for enduring CSA. In her initial study, Wyatt (1985) found no differences among CSA prevalence rates for African American and White women. However, a comparison study conducted ten years later found rates to be slightly higher for White women (Wyatt, Loeb, Solis, & Carmona, 1999). Other studies have found CSA prevalence rates to be higher for Hispanic women (Young, et al 2007) in comparison to White, African American, Asian, and multi-racial/ethnic women. These studies provide great insight into the importance of including race and ethnicity in studies of CSA. They also present the possibility of African American women being at least risk for CSA. However, it is important to consider two factors when drawing conclusions

about vulnerability of CSA among African American women: (a) the disproportionate number of African American participants in research studies and (b) silence surrounding CSA in the African American community.

Effects of CSA in African American women

The long-term effects of CSA are fairly the same for women across all racial and ethnic groups. Thus, African American women experience dysfunction in many of the same areas as other women who also have endured CSA. Similar to other survivors, African American women experience negative consequences that impact them: psychologically (Sciolla, Glover, Loeb, Zhang, Myers, & Wyatt, 2011; Lestrade et al., 2013), physically (Lane, Kaslow, Thompson & Kingree, 2000; Urquiza & Goodlin-Jones, 1994; West, 2002), sexually (Wyatt, 1990; NIMH, 2010), and relationally (Liang, Williams & Siegal, 2006; Singh, Garnett & Williams, 2013). However, African American women who have survived CSA are faced with the challenge of dealing with negative consequences that are far more complex and exacerbated for them. In particular, race-related factors unique to African American women make the journey to recovery from trauma more difficult for these women. Racism, sexism, and classism all intersect with the long-term effects of CSA and add another layer for African American female survivors of CSA. African American women have been experiencing social oppression and injustice in the U.S. for years. These experiences not only shape daily functioning, but also shape how these women heal from CSA in this country (Singh, Garrett & Williams, 2013).

African American females (particularly youth) are more likely to engage in risky sexual behavior than youth from any other racial or ethnic group (Wilson, Emerson,

Donenberg, & Pettineo, 2013). There could be multiple reasons for why African American females engage in such behavior, but an experience of CSA is by far one of the top reasons. Johnson et al., (2011) found sex trading, multiple partners, lack of condom use, and sexually transmitted diseases to be most prevalent among women with a history of sexual trauma in their study, which was made up predominately of African American women. Risky sexual behaviors create great concern for society because outcomes have the potential to affect the health of the survivor and others in the community. One of these outcomes is the contraction and spread of sexual illnesses, such as HIV/AIDS.

HIV/AIDS is the leading cause of death among African American women between the ages of 25-34 in the U.S. (Center for Disease Control and Prevention as cited in Machtinger, Wilson, Haberer, & Weiss, 2012) and African American women make up 65% of new HIV infection cases in the U.S., which is the highest among all female groups (Centers for Disease Control and Prevention [CDC], 2012). African American women who are HIV positive are likely to have a history of CSA (NIMH, 2010). Women of all racial and ethnic backgrounds who have this illness and a history of CSA are faced with the challenge of coping with their trauma and illness. They have to find a way to navigate their individual and relational lives as women with a history of CSA and a permanent, life threatening illness. Unlike other women, African American women have to deal with these things and the element of how race-related factors play into navigating both worlds. The stigma surrounding disclosure, shame associated with both CSA and HIV/AIDS, and mistrust in helping systems leave African American women with few options to aid them.

Revictimization is exposure to physical, emotional, and psychological abuse in adulthood at the hands of a significant other after enduring abuse in childhood. In a sense, revictimization continues the process of abuse in adulthood, leaving victims unable to escape the cycle of abuse. Intimate partner violence (IPV) is the form of revictimization that occurs most frequently among CSA survivors. Women who have endured CSA are 2.3 times more likely to experience IPV than women who have not endured the same abuse (United States Department of Justice, 2000). Of all female survivors, African American women are more prone to experience IPV. According to Urquiza and Goodlin-Jones (1994), over half of African American women who experience CSA will endure sexual revictimization in adulthood, which is greater than the chances of women from other racial and ethnic groups. Similar findings were reported by Hattery (2009) who found all African American women in her study had experienced both IPV and CSA while White women who endured IPV experienced little to no CSA.

Even though CSA increases the chances of experiencing IPV for women, risk for enduring IPV increases with or without an experience of CSA for African American women. In 2010, 43.7% of African American women reported that they experienced IPV at some point in their lifetime (National Center for Injury Prevention and Control, 2011). These rates show how abuse of any kind is prevalent among African American women. Some of the reasons for the high prevalence of IPV among African American women include: a mistrust in government systems (e.g., police and court systems) leading to decisions not to report, fear of involving partners in the criminal justice system which is

perceived as oppressive in the African American community, and financial constraints that could arise after partner incarceration (Bryant-Davis, Chung, & Tillman, 2009).

Similar to other women, African American women are frequently diagnosed with depression, PTSD, and other mental illnesses following their experience of CSA. However, it is quite possible rates of mental illness among African American women are inaccurate due to the lack of disclosure and secrecy surrounding CSA in the Black community. A recent report from the U.S. Department of Health and Human Services (2013) found African American individuals are less likely to receive treatment for mental health than those from other racial and ethnic groups. This is a possible explanation as to why rates of mental illness for African American female CSA survivors are either lower or similar to the rates of other women. In their study of unmet health needs, Ngui & Flores (2007) found mental health needs to be most unmet for African American females in comparison to all others in the study. This means African American women, especially those who have endured CSA are not getting the necessary mental health treatment they need. Possible causes of why mental health needs are unmet for African American women are: (a) beliefs that therapy is ineffective, (b) torn beliefs about disclosing information, and (c) inability to relate to a therapist who does not share the same race and culture (Bryant-Davis, 2005). Financial constraints and unequal access to resources also play a crucial role in willingness to seek mental health treatment. Many African American women survivors do not have the finances to receive quality care nor are they given equal access to quality mental health care (Bryant-Davis et al., 2009; Bryant-Davis & Ocampo, 2005). These limitations leave CSA survivors to battle mental

illness associated with the trauma and possible feelings of inadequacy and unworthiness, which could lead to exacerbated mental illness.

Intimacy among African American Women

Change in Marital Trends among African Americans

The marital trends among African American heterosexual partners have drastically changed since the 19th century. During the 19th century, over 75% of African American men and women between the ages of 34-44 were reportedly married (U.S. Bureau of the Census, 1979). African American partners also were least likely to be unmarried (Elliott et al., 2012) and less likely to divorce (Allen & Olson, 2001). These trends suggest marriage and maintaining marriage were important factors to African American partners during this time. Marital trends among African Americans partners began to change around the end of the 20th century (Elliott et al., 2012). Between the timeframe of 1980-1990, marital rates decreased and divorce rates increased among African Americans (U.S. Bureau of the Census (2010a). These changes continued through the end of the 20th century and characterize current marital trends among African American partners. Today, African American partners are least likely to marry, more likely to delay marriage, and more likely to divorce (Allen & Olson, 2001; Dixon, 2009). While it is likely that marital trends have changed for all racial and ethnic groups across the board since the 19th century, changes are most apparent among African Americans. In comparison to other racial and ethnic groups, African Americans have the lowest marital rates, highest divorce rates, and highest rates of individuals who have never been married (Chambers & Kravitz, 2011). These marital trends show that marriage and intimate relationships are within a state of crisis among African Americans. The changes

in relationship trends may be linked to: (a) historical sexual trauma of Black women, (b) Black relationships after slavery, and (c) experiences of racism and oppression among Black partners.

Historical Sexual Trauma

Intimacy patterns among African American women cannot be discussed without examining the historical sexual trauma women of African descent experienced in America. The sexual trauma of African American women began during slavery and continues today. The sexual trauma Black women experienced during slavery may be the main contributing factor to relational difficulties African American women experience today.

The era of slavery had negative consequences for Black men and women and their romantic relationships. However, Black women may have experienced the most trauma, leading to the long-term negative effects we see today. During slavery, Black women experienced a great deal of unwanted touch, sex, and forceful sexual engagement by slave masters and Black enslaved men (Foster, 2011; Jennings, 1990). While it is estimated that 58% of Black women between the ages of 15-30 were sexually assaulted in some form during slavery (West & Johnson, 2013), it is likely this is an underestimation. Laws in place during slavery prevented slave masters from facing consequences for their rape and exploitation of Black women (Davis, 2002; West & Johnson, 2013). The actions of slave masters were justified on the grounds of: (a) beliefs that Black women were hypersexual (Christensen, 1988) and (b) need to increase the slave population (West & Johnson, 2013).

In addition to being raped by White men, Black women also experienced rape at the hands of Black men. However, rape endured by Black men occurred under different circumstances than the rape committed by White men. "Rape" committed by Black men was primarily for the purposes of forced breeding (Foster, 2011; Jennings, 1990), thus, putting it in somewhat of a different category. Forced breeding was the sexual pairing of Black men and women for the purposes of producing offspring that would be sold for profit (National Humanities Center, 2007). Sadly, laws also did not protect Black women from sexual violence committed by Black men. The actions of Black men were allowed and not classified as rape on the grounds that: (a) slaves did not have rights, (b) children from rape created more profit, and (c) Black women's "innateness for promiscuity" (Getman, 1984). The rape committed by Black men at the command of White slave masters was the start of the destruction of trust between Black men and women (Getman, 1984). The forcing of sexual contact left Black men and women in positions of powerlessness and hopelessness. It robbed enslaved women and men of healthy touch and sex that could lead to satisfying physical and sexual intimacy. According to Pinderhughes (2002), sexual trauma during enslavement is the main contributor to the issues African American women have with intimacy.

The exploitation of Black women continued after slavery. Post slavery, demeaning and controlling images were used to continue the exploitation of African American women. For example, the Jezebel image portrayed the Black woman as a promiscuous creature who could not be raped because she constantly desired sex (Windsor & Dunlop, 2011; West & Johnson, 2013). The true nature of this image and like images was to justify the rape, exploitation, and objectification Black women

endured during slavery. While the negative portrayals of African American women began in slavery, such portrayals continue today, even in songs by Black male music artists. In songs such as “Hoochie Mama” (2 Live Crew) and “Freak Shawty” (Luke), African American women are given labels such as “Freak, Ho, and Hoochie Mama” (Collins, 2000), all of which are contemporary names for the Jezebel. These labels (Jezebel, Freak, and Hoochie Mama) serve the purpose of sexually exploiting and objectifying the Black woman.

African American Relationships: Pre and Post Slavery

Slavery sought to destroy intimate relationships between enslaved men and women. It severed the once strong and resilient bonds between Black men and women in committed relationships and marriages. During enslavement intimate bonds between Black men and women were destroyed by: (a) the buying, selling, and trading of slaves (Lawrence-Webb et al., 2004); (b) forcible separation (Hill, 2006); and (c) forced breeding (Foster, 2011; Jennings, 1990). These experiences left Black men and women unable to develop healthy physical and sexual relationships due to intimate encounters being controlled and manipulated by the slave trade.

The unity of marriage definitely changed as a result of enslavement. During this period, Black men and women were denied the right to legalize their unions. Entering a legal marriage contract was not possible for individuals who were considered property (Hill, 2006). Despite their inability to legally enter a marriage, Black men and women still operated as husband and wife even though their unions were under constant threat of separation (Williams, n.d). Partners (especially males) were constantly being ripped apart and sold elsewhere (Hill, 2006), which left the relational unit fragmented.

Following the end of slavery, separated men and women showed the strength of their bonds by attempting to unify with spouses who had been forcibly torn from them (Tolman, 2011).

Even though slavery ended in 1865 (General Records of the U.S. Government), African Americans continue to be plagued by this period in history. Many of the struggles in the African American community can be attributed to the enslavement that occurred in the U.S. A lack of employment and resource stability following slavery left Black men and women with little ability to achieve economic prosperity. Thus, African Americans have faced a significant amount of economic strain since the end of slavery. Research examining income and marital quality found there is a correlation between low-income status and marital quality in that low-income status does correlate to low marital quality and vice versa (Brown et al., 2013). According to Bryant et al. (2010), financial stress and strain, especially among low-income partners, has contributed to partnership breakdowns within the African American community.

There is currently a shortage of men in comparison to women in the African American community (Harknett & McLanahan, 2004). In the African American community, population rates of women supersede rates of men, creating a huge sex ratio imbalance (Curran et al., 2010). High rates of incarceration (Lane et al., 2004) and mortality (Harknett & McLanahan, 2004) are the top causes of this sex ratio imbalance. African American men face imprisonment and death at alarming rates in the U.S. Recent data shows approximately 1.5 million African American men are missing from the American society due, in large, to imprisonment and homicide, creating a sex ratio of 100:83 among women and men between the ages of 25–54 (Wolfers, Leonhardt, &

Quealy, 2015). According to Lawrence-Webb, Littlefield, & Okundaye (2004), forcible partner separation caused Black men to become invisible and Black women to become more visible. Thus the sex imbalance between African American men and women may function similarly to forcible partner separation in slavery, impacting the development of intimate relationships and marriage.

African American Relationships: Oppression and Racism

Partners from every racial and ethnic group experience trials and tribulations that test the stability of their relationship. However, African American couples experience trials that are unique to them. Research has shown that African American partners experience greater stress than Whites, which has a negative impact on the relationship (Broman, 1993). Stressful life events that African American partners face include racism and oppression (Carolan & Allen, 1999). The stress from these external factors not only impacts individual functioning, but interpersonal functioning as well, which can severely impact intimacy in the relationship. The oppression and racism African Americans face in the U.S. are direct results of enslavement. Dixon (2009) identified the causes of marital/relational change among African Americans as: structural (unemployment and financial issues, incarceration and imbalance of sex ratios, decisions of Black men to not marry Black women); cultural (cohabitation as an option, family ties more important than marriage, Hip Hop era); and individual (independence of women, premarital views and perceptions of marriage). Another contributing factor was the changes to drug and welfare policies, which has had the severest consequences for African Americans (Elliott et al., 2012).

Contemporary African American partners continue to show great resiliency, but oppression and racism still appear to have negative impacts. Thus, racism and oppression continue to pull African American relationships apart. A major outcome of the stress African Africans endure today is male to female violence. African American women make up approximately 8% of the population, but account for 22% of the homicides that occur due to domestic violence in the U.S. (Jones, 2014). Stressful life events that put African American women at risk for domestic violence include: under employment, living in poverty, alcoholism, and jealous partners who need to exert power over female partners (Institute on Domestic Violence in the African American Community, 2008), all of which are social issues that go ignored in our society.

While laws of injustice are not as blatant as they were during the period of segregation, laws and practices of today still have negative impacts on the intimate relational systems of African Americans. For example, individuals who have experienced incarceration are extremely limited in their ability to advance in U.S. society due to laws put in place. A lack of access to resources limits one's ability to gain educational and wealth advancement, which has the potential to negatively impact the overall health functioning of an intimate relationship (Lawrence-Webb et al., 2004).

Research examining intimacy between African American partners often fails to examine how race and oppression factor into the intimacy patterns of African American people. The examination of intimacy and love in the U.S. has primarily been conducted with White Americans (Carr, 2002). African Americans largely have been excluded from these examinations, yet results are often generalized to them. This process of generalization is dangerous because it excludes important differences between African

Americans and White Americans that contribute to how intimacy is created and maintained in relationships. For example, African American relationships largely have operated as egalitarian in the past and present (Lawrence-Webb et al., 2004). Despite the egalitarian nature of relationships, African Americans are often forced to operate under a patriarchal system, which creates breakdowns in the relationship (Lawrence-Webb et al., 2004). Research conducted from the White (or European) viewpoint excludes the ways in which African American relationships have been impacted by slavery and oppression in the U.S. To fully understand the construction and operation of intimacy between African Americans, history and racial aspects unique to African Americans need to be examined and included in the discussion (Dixon, 2009).

Studies that do incorporate African Americans sometimes produce results that do not fit within the culture. Bernstein (1991) concluded that intimacy is not a central issue in life for African Americans. Taub and McEwen (1991) found White students scored significantly higher than African American students on a measurement that examined the development of interpersonal relationships through verbal intimacy. Based on the results, it would appear as though White students are better at developing interpersonal relationships than African American students through the use of verbal intimacy. However, lack of a balance between the number of research participants (more White than Black students) and the examination of intimate relationships through one form of intimacy may explain why African Americans' scores were lower than Whites (Taub & McEwen, 1991). Despite efforts to destroy intimacy through enslavement, oppression, racism, and current negative views of Black male-female relationships in the African American community, African American men and women continue to strive for intimate

relationships. African American women in particular desire intimate, romantic partnerships. They view intimacy as important and perceive romantic partnerships to be the most important source of intimacy (Brown & Gary, 1985).

Physical and Sexual Intimacy among African American CSA Survivors

Strength and independence are two traits many African American women possess. African American women are praised greatly for their ability to display independence and strength despite the challenges they may endure in life. While these traits are perceived as positive, they also can create false perceptions of African American women. In particular, perceptions of African American women as strong and independent can lead to beliefs that these women do not desire intimate relationships. It should not be assumed that African American women do not desire intimate relationships or marriage because they function as strong and independent individuals (Carr, 2002). African American women do indeed desire intimate relationships with significant others.

The interplay between CSA and intimacy functioning in adult relationships has been widely explored. However, research into this connection largely has been done with White study participants. The generalization of results to other racial and ethnic groups helps to understand that there is a connection between CSA and intimacy in adulthood, but it does not show the role racial or ethnic differences play in this connection. There has been little examination into the ways in which an experience of CSA impacts the intimate lives of African American female survivors. Furthermore, even less research has been done examining ways in which CSA affects the physical and sexual intimacy of these survivors. It may be safe to say this research is nearly nonexistent. It is necessary to examine how CSA affects physical and sexual intimacy among African American

females considering they are most: (a) likely to endure CSA, (b) susceptible to negative effects of CSA, and (c) relationally injured by historical sexual trauma in the U.S.

Black Feminist Thought (BFT) and Womanism

Definition and Components of BFT and Womanism

BFT is a critical social theory with the goals of resisting oppression and empowering African American women (Collins, 2000). While BFT is often associated with the work of Patricia Collins, it actually encompasses more than just her ideas. Womanism, coined by Alice Walker (Floyd-Thomas, 2006), is seen as a viewpoint that is synonymous with BFT (Taylor, 1998). The differences in names may make it seem as though the works of Collins and Walker are in great opposition to each other, but they have more similarities than differences, putting them under the same umbrella. The main commonalties between the two viewpoints are their focus on African American women's self-definition and self-determination (Collins, 1996).

Despite the commonalities, debates about the differences between BFT and Womanism are ongoing, which have been challenged by Collins. Collins (1996) postulated: "Perhaps the time has come to go beyond naming by applying main ideas contributed by both womanists and Black feminists to the over-arching issue of analyzing the centrality of gender in shaping a range of relationships within African American communities" (p.15). In a *New York Times* article Walker even discusses the link between Womanism and BFT by explaining, "I don't choose Womanism because it is 'better' than feminism ... Since Womanism means Black feminism, this would be a nonsensical distinction. I choose it because I prefer the sound, the feel, the fit of it….I dislike having to add a color in order to become visible, as in Black feminist. Womanism

gives us a word of our own" (as cited in Hayes & Steinem, 1998, para. 2). While the features of BFT and Womanism will be separately discussed below, it is important to note both fall under the same category.

Black feminist thought (BFT) "consists of ideas produced by Black women that clarify a standpoint of and for Black women" (Collins, 1986, p. 16). It acknowledges that the realities of African American women can be seen from positive viewpoints and assists in creating an understanding of the strength, resiliency, and struggles of these women (Jones, 2015). BFT grew out of feminism. Believing that African American women were absent and invisible in the discourse on feminism, BFT was created to focus on the issues of African American women (Taylor, 1998). Collins (1986) highlights three key themes of importance to BFT: (a) "self-definition and self-valuation" (p. 16); (b) "the interlocking nature of race, gender, and class oppression" (p. 19); and (c) "redefining and explaining the importance of Black women's culture" (p. 21).

Recognition of the oppression African American women have faced in the U.S. is a key component of BFT. According to Collins (2000) three interdependent dimensions make up the oppression African American women have endured: (a) exploitation of Black women through work labor during slavery, (b) denial of political rights and privileges that were afforded to White male citizens, and (c) stigmatization via controlling images (e.g., Jezebal, Mammy) that view African Americans negatively. As one can see, African American women have been oppressed in the U.S. society since the days of slavery. BFT seeks to stand against the systems that oppress African American women in the U.S. society. This school of thought acknowledges African American women's position as a subordinate group in the U.S. and seeks to change oppression into

empowerment. Thus, BFT aims to empower African American women to stand against the system of social injustice that surrounds them (Collins, 2000) and value themselves and the knowledge they possess (Collins, 1989).

Alice Walker is deemed the originator of Womanism. Womanism was coined by Walker in 1985 in her book "In Search of Our Mother's Gardens" (Floyd-Thomas, 2006). This viewpoint "reflects a link with a history that includes African cultural heritage, enslavement in the United States, and a kinship with other women, especially women of color" (Hayes & Steinem, 1998, para. 3). A key feature of Womanism is the focus on incorporation versus separation from Black men. Womanism does not call for a separation from Black men; instead the goal is to work on developing stronger relationships with these men (Collins, 1996).

Collectively, BFT and Womanism are appropriate constructs through which to explain the issues African American women endure because they acknowledge the importance of highlighting the marginality of African American women. They acknowledge the unique position of the outside/within construct (Collins, 1986) and African American women are given the chance to look at themselves and the surrounding world differently (Collins, 1989).

Chapter 3: Methodology

Purpose of Study

The purpose of this study was to explore the experiences of physical and sexual intimacy in opposite-sex, romantic relationships among African American females who have endured CSA.

The research questions used to help guide this exploration were:

1) How do heterosexual, African American female survivors of CSA experience physical and sexual intimacy in their current romantic relationships?
2) How (if at all) do heterosexual, African American female survivors of CSA believe an experience of CSA has influenced their experience(s) of physical and sexual intimacy?
3) In what way(s) do African American female survivors of CSA believe their current partners have influenced their experiences of physical and sexual intimacy?

A qualitative methodological approach was used to explore these research questions. Specifically, transcendental phenomenology using Colaizzi's (1978) method of analysis was employed. This chapter will elaborate on the methodology that was be used in this research study and offer a rationale for each methodological decision. The following will be discussed: (1) research methodology, (2) phenomenology inquiry, (3) researcher biases, (4) data collection, (5) data analysis, (7) trustworthiness, and (8) ethical considerations in qualitative research.

Research Methodology

Qualitative research is an interpretative, naturalistic approach that attempts to understand individuals and situations within their unique contexts (Creswell, 1998; Merriam, 2002). The primary goal of qualitative research is to capture and disseminate participants' accounts of their full experience (s). Qualitative research emphasizes the importance of understanding the process and meaning of human context and learning how individuals experience themselves and the external world (Denzin & Lincoln, 1994; Merriam, 2002). Thus, qualitative researchers seek to explore and understand human context and its' functioning on both an individual and societal level. Topics in the social and human sciences are explored with this research and issues such as gender, race, culture, and marginalization in human context are highlighted (Creswell, 1998). It is important for such issues to be highlighted by qualitative researchers because they have the greatest influence on human context and functioning in society. Qualitative research draws from multiple disciplines and methods, thus it does not belong to any one discipline (Denzin & Lincoln, 2011; Rossman & Rallis, 2003). The eclectic nature of qualitative research makes it fitting for the examination of the human context, which contains endless diversity and variety. There are key features of qualitative research that are universal to all studies. These key features are:

> (1) researchers strive to understand the meaning people have constructed about their world and their experiences; (2) the researcher is the primary instrument for data collection and data analysis; (3) qualitative research is inductive—researchers gather data to build concepts, hypotheses, or theories rather than deductively deriving postulates or hypotheses to be tested (as in positivist

research); (4) research is richly descriptive (words and pictures rather than numbers are used to convey what the researcher has learned) (Merriam, 2002, pp. 4-5).

Qualitative research methodology was chosen because core components of this research method fit with the overall goals of the study. The main goals of this study were to: (a) gain an understanding of how an experience of CSA among selected individuals (African American women) influences their physical and sexual intimacy at an individual and relational level and (b) validate/honor the experiences of this group of women by providing an in-depth, rich description that details their experience of this phenomenon (Richards & Morse, 2007). This methodology also was chosen because of the important role the researcher played throughout the research process. The qualitative methodology most suited for this study was phenomenology. This was the most appropriate methodology due to the match between the researcher's goals and purposes/goals of phenomenology.

Phenomenological Inquiry

German mathematician and philosopher Edmund Husserl (1859-1938) is credited with spearheading the phenomenology movement in 1913 with his creation of the branch called transcendental phenomenology (Converse, 2012). While Husserl is responsible for sparking the phenomenology movement, he is not the only contributor to this inquiry. Others such as Heidegger, Satre and Merleau-Ponty also are seen as vital contributors to the shaping of phenomenology (Giorgi & Giorgi, 2003).

Phenomenology is an interpretive and descriptive approach that originates from the school of philosophy (Dowling, 2007; Wojnar & Swanson, 2007; Flood, 2010).

Thus, philosophical components create the foundation for phenomenology. The goals of this inquiry are to explore and understand life experiences through the eyes of individuals in society and capture the meaning attached to these life experiences (Starks & Brown-Trinidad, 2007). Thus, researchers investigate participants' lived experiences of a phenomenon and aim to reduce the findings into a description that is reflective of how things appear through the eyes of these individuals (Creswell, 2007; Omery, 1983). Essentially, researchers using this inquiry are responsible for gaining firsthand knowledge about a phenomenon that participants have experienced and compiling a description of these collected experiences to provide a detailed account for readers. Today, phenomenology is widely used in the social and health sciences (e.g. sociology, psychology, anthropology, nursing, and education) (Creswell, 2007; Hays & Singh, 2012). Phenomenology is well suited for these areas because they share the common goal of understanding human processes and experiences. There are 7 phenomenological inquiries identified in the *Encyclopedia of Phenomenology*: transcendental (descriptive), naturalistic, existential, generative historicist, genetic, hermeneutic (interpretative), and realistic (Embree, 1997).

Phenomenology places great emphasis on learning the cognitive experiences of people and understanding how they affect the individual (Flood, 2010). The importance of learning individuals' experiences of life events and understanding how they affect the individual are the main reasons phenomenological inquiry was used for this study. CSA and its impact on intimacy has been vastly explored and discussed in multiple research studies (Bacon & Lein, 1996; DiLillo & Long, 1999; Roberts et al., 2004). Past research has done a great job understanding experiences and effects of CSA on intimacy processes

through the eyes of White female survivors. However, research on how an experience of CSA impacts physical and sexual intimacy through the eyes of African American women is nearly non-existent. Research often tells the story through the eyes of White female participants (Clark et al., 2012; Fairweather & Kinder, 2013; Young et al., 2007; Vaile Wright, Collinsworth, & Fitzgerald, 2010), which is non-sufficient for African American female survivors. Phenomenology was an excellent choice for this study because it allowed the researcher to explore and understand this phenomenon through the lens of the African American participants.

This inquiry also was chosen because it aligned with the overall purpose of conducting the study. The overall purpose of this study was to allow marginalized women to share their accounts of sexual and physical intimacy in their adult relationships after an experience of CSA. The goal was to gather multiple accounts of this experience and capture a description that gives justice to what these women have endured. Phenomenology allowed several accounts of this experience to be heard and merged together to create a full description that explained this phenomenon. This study would finally give a voice to the missing CSA survivors in research.

Researcher Bias

The researcher plays a very important role in a phenomenology research study. She/he is primarily responsible for: selecting the research topic, structuring the study, engaging participants, and collecting and analyzing data (Creswell, 2007). Considering the important role researchers play in their research, it is important to know the factors that influence their decisions. Every decision made by a researcher grows out of his or her social location(s) in society. For example, the decision to study the phenomenon of

physical and sexual intimacy among African American female survivors of CSA grew out of the personal experiences of the researcher. As a woman who has survived CSA, the researcher decided to embark on the journey of understanding the experiences of other women who have shared this same experience. The decision to conduct the research with African American women grew from the researcher's location as an African American woman and beliefs about the limited stories/voices of these women in the literature. Finally, the decision to explore physical and sexual intimacy in a dyad stems from the researcher's location as a partner and beliefs about the importance of discussing intimacy patterns of partners within the context of a relationship. All of these things were captured with the use of phenomenology.

Another important role of the researcher is acknowledging assumptions and potential biases related to the study. The researcher assumed two things would grow out of this phenomenological exploration: (a) women would report CSA has influenced their experiences of physical and sexual intimacy in some shape or form and (b) women's reports of partners' influences on intimate experiences would be determined by partners' understanding of how CSA impacts physical and sexual intimacy. These assumptions grew out of personal experiences and clinical/nonclinical work with this population of women. Two glaring biases focused solely on African American women and CSA. There are two levels to these biases: (a) racial location as an African American and (b) beliefs about CSA experiences. It could be argued that the researcher was showing bias by only focusing on African American women. This could lead to assumptions that the researcher believes only African American women experience this phenomenon. While the researcher does not believe that African American women only experience CSA, she

does believe that the voices of African American female CSA survivors largely are absent from the literature. Another bias shown is singling out women who have experienced CSA. One could argue that women who have experienced any form of abuse could encounter issues in their physical and sexually intimate relationships. However, women who have experienced CSA specifically are at risk for having difficulty in their physical and sexual intimate relationships.

The responsibilities of a phenomenological researcher are most complex during the interview process. During the interview process, phenomenology researchers have the responsibility of simultaneously: remaining neutral, asking open-ended questions, engaging participants in dialogue, tracking participants' speech, clarifying thoughts and ideas, and using reflective dialogue (Burns & Grove 2003). The key to being able to fully engage with participants during the interview and gather the true essence of their story is bracketing.

Bracketing

Bracketing requires the researcher to identify and acknowledge prior beliefs, thoughts, and feelings about the phenomena being studied and set them aside (McCaslin & Scott, 2003). This process is extremely important for a researcher conducting a transcendental phenomenology study. The exclusion of this process could possibly contaminate the data being gathered by participants (Burns & Grove, 2003). Contamination would then lead to a final product that is a reflection of the researcher's inner processes and not the participants. The process of bracketing also allows the researcher to play that pivotal role in research without overshadowing or interjecting in the process of creating the final description of the narratives (essence). It achieves the

goals of: (a) giving participants full responsibility for telling their experiences, (b) giving them ownership of their accounts, and (c) eliminating the possibility of creating a description that is a blend of participants' experiences and researchers' stances and thoughts. The phenomenon under examination warranted separation to allow participants to be the main storytellers of their own experiences as they are the experts of their own lives. The researcher engaged in bracketing while conducting this study to ensure that this potentially dangerous process did not occur. To bracket, the researcher kept a detailed journal that recorded all thoughts, feelings, beliefs, and prior knowledge that arose during the course of data collection and analysis.

Self of the Researcher

Engagement and completion of this research study was an extremely rewarding experience. One may assume work with CSA survivors would be emotionally and mentally taxing for a CSA survivor, but the opposite occurred during this study. As a CSA survivor, several opportunities arose for parallels to be drawn between participants' story and the researcher's. The ability to see similarities (and differences) validated the importance of understanding how CSA impacts African American women and intimacy with partners.

Data Collection

Sampling and Selection

A phenomenological study aims to gather participants who have experienced the phenomenon being investigated by the researcher. Thus, researchers are required to purposely select a sample of participants that can provide an "understanding of the research problem and central phenomenon being studied" (Creswell, 2007, p.125). Two

forms of sampling were used to gather participants for this study: criterion and snowball sampling. Criterion sampling suited this study because it required the selection of participants who have experienced the phenomenon being examined (Creswell, 2007). In this study, the researcher gathered a sample of participants who met the main criteria of having experienced CSA and identified as African American women. Snowball sampling was used as a secondary sampling method. This sampling method was used to assist the researcher in identifying participants of "interest from people who know people who know what cases are information-rich" (Creswell, 2007, p. 127). The combination of criterion and snowball sampling produced a sufficient number of participants for this study.

The number of participants needed for a phenomenological study is greatly varied in the literature. For example, Polkinghorne (1989) recommends selecting 5 to 10 individuals while Starks and Brown-Trinidad (2007) state a range between 1 and 10 is sufficient. Others state the circumstances of the phenomenon being studied determine the number of participants needed for a study. Factors that can be used as determinants are: the scope of the study, the nature of the topic, the quality of the data, the study design, and the use of shadowed data (when participants speak of others' experience as well as their own) (Morse, 2001; Morse 2002; Starks & Brown-Trinidad, 2007). The nature of the topic (CSA) did create some difficulty in finding research participants. However, the researcher was able to recruit a participant sample of ten individuals which allowed the production of a rich and detailed account of this phenomenon.

Recruitment

Diversity among recruitment locations heightened the possibility of gathering the number of individuals needed for the study sample. The researcher identified three locations within the Philadelphia area that catered to the population (heterosexual, African American women with a history of CSA who are currently in a romantic relationship) needed for this study. The locations were as followed: (a) Enon Tabernacle Baptist Church,

(b) Individual, Couple and Family Therapy Clinic, and (c) Therapy Center of Philadelphia. The researcher identified a key individual at each site and built a rapport with each, which included becoming familiar with the specifics of the location through their knowledge. The key individual at each identified location was used as the primary resource for assistance with getting permission to recruit participants. Research fliers containing the details of the study and pertinent contact information were distributed to each location via hard copy and digital form. In addition to supplying fliers to specific sites, fliers were distributed to individuals who could assist with recruitment through their access to the population being studied (snowball sampling). Upon distribution of the flyers, the researcher was available to answer any questions, concerns, and/or offer any clarification(s) needed about the study.

Procedure

All necessary documents were completed and submitted to the Institutional Review Board (IRB) of Drexel University for study approval prior to beginning research. After approval was granted by the IRB, recruitment of research participants took place. Advertisement flyers (Appendix A) were distributed to the contact representatives of

locations that were selected as recruitment locations. Flyers also were posted in approved areas around Drexel University and given to Dr. Erika Evans-Weaver (a committee member) of Widener University who assisted with solicitation of research participants.

The selection of research participants was based on strict criteria. The criteria was as follows: (a) identification as an African American female, (b) between the ages of 25-45, (c) current involvement in a partnership, (d) identify as heterosexual, (e) currently has a male partner, (f) has been in the relationship with this male partner for a minimum of one year, (g) has disclosed experience of abuse to one's partner, and (h) received therapeutic treatment of some sort for the abuse that has been endured.

Only African American women were selected based on the limited voices of African American CSA survivors in the literature, particularly since African American women are more likely to endure CSA (Perez-Fuentes et al., 2013; Young et al.Young, 2007; Ullman & Filipas, 2005; Urquiza & Goodlin-Jones, 1994; Senn et al., 2006). Since the primary goal of this study was to understand intimacy in heterosexual relationships after an experience of CSA, it was important for women to be involved in a current relationship. However, memory and recall of past intimate relationships could have been problematic. Thus, selecting women currently in an intimate relationship with a male partner for at least one year established manageable boundaries and maximized the potential for richer data. Being in a relationship for at least one year, participants were likely to have commitment and an understanding of their relational intimacy. It was likely that individuals between the ages of 25-45 had experienced a significant relationship and a level of maturity that allowed them to assess their intimate experiences. Additionally, the selected age range provided a broader perspective as intimacy may look differently

based on age. Since the focus was on relational intimacy which involves communication (Waring, Tillman, Frelick, Russell & Weisz, 1980) and trust (Mayseless & Scharf, 2007), it was necessary for participants to have disclosed their experience of CSA to partners. Also, the study asked specific questions relative to the partner's knowledge of the CSA. Finally, prior therapeutic treatment or support for the CSA was critical to reduce the potential for harm to participants and increase their level of comfort with discussing CSA.

Once interested participants made initial contact, the researcher determined if inclusion criteria were met (Appendix B). The determination of inclusion took place via email and phone. An interview was scheduled for all potential participants who met the inclusion criteria. Every participant was asked to participate in both the interview (lasting approximately two hours) and member checking processes (lasting no longer than an hour) (Sanders, 2003). Participants were given the option to meet in a secure location (Miller, 2008). Once a participant provided verbal consent to participate in the study, they were given the Drexel University consent form (Appendix B) for review. The consent document (Appendix B) was sent to the participant via email for her review prior to the initial interview (the consent form was reviewed with the participant prior to the start of the interview).

The researcher conducted each interview with the participants. Prior to beginning the interview, the researcher obtained research consent (Appendix B) and provided the participant with the demographic survey (Appendix D) for completion. Pseudonyms also were identified for each participant who consented to the use of one before starting the interview. The pseudonyms given to each participant also were used to replace any

identifying information of the participant (Miller, 2008). All interviews were audio-recorded using two selected portal recording devices (one as a backup recording device). Immediately following the interview, the audio recording was uploaded into a secure Dropbox folder for transcription. The Dropbox folder was shared only by the researcher and transcriber. Each transcript was stored on an approved encrypted USB flash-drive retrieved from the Information Resource and Technology (IRT) Department at Drexel University. The encrypted flash-drive also was password protected for additional security. The dissertation chair and the researcher were the only individuals who had knowledge of the password. Additionally, the audio tape recordings and transcripts were stored separately from the demographic surveys (information) and consent forms, which indicated the participant's identity. Along with the dissertation chair, the researcher was the only individual who had access to the demographic surveys (information) and consent forms, as it was necessary to ensure the privacy and confidentiality of participants (Miller, 2008). The researcher stored the original participant information in another password protected and encrypted document in a locked area (Three Parkway Building, 2nd and 3rd Floors) designated for research by the College of Nursing and Health Professions. After the interview, participants were asked if they would like to participate in the member checking process. They were informed that future contact would be made via email to send them preliminary study results if they consented to this process. If consent was granted, the researcher scheduled a member checking interview with the participant. Each participant was thanked for her participation and provided with a $25.00 gift card after the completion of the initial interview.

Interview structure

Each interview was conducted within a 2-hour window (Miller, 2008). The initial interview required the use of a 1 to 2 hour timeframe, but the second interview (member checking) was conducted in less than 1 hour. There was variation in the length of the initial interview with some being closer to 2 hours and others being under an hour. Most of the initial interviews took approximately an hour to complete. The researcher conducted an in-depth, semi-structured interview using broad and probing questions (Creswell, 2007; Miller, 2008) with each research participant (Appendix C). This format allowed the researcher to use loose, broad themes and probes to gather elaborate accounts from participants (Qu & Dumay, 2011).

During the interview, participants were asked to describe their experiences of CSA and physical and sexual intimacy in the context of their current relationships. Throughout this process, I asked probing questions "to assist the participants with sharing more about their experience" (Miller, 2008, p.72) and enhance my understanding of the described experience(s).

Immediately following each interview, the researcher engaged in the process of reflexivity. This process involved reflecting on the experience and writing any emerging thoughts, feelings, and ideas about it in a journal (Carlson, 2010; Miller, 2008; Wojnar & Swanson, 2007; Sanders, 2003). These reflections were shared in a debriefing session with a peer advisor. Upon completion of the data analysis process, consenting participants were sent a confidential summary of only their preliminary results for member checking (Sanders, 2003; Shosba, 2012).

Interview techniques

The researcher spent time building a rapport with each research participant to establish a safe and comfortable environment conducive to sharing personal experiences (DiCicco-Bloom & Crabtree, 2006). During this time, participants also were informed that answers could be neither right nor wrong as the researcher was interested in hearing their personal experiences (Miller, 2008). If a participant inquired about the researcher's personal connection to the topic at hand, space was created for the researcher to address any questions that arose. Dialogue about the researcher's connection to the topic was used for the purposes of: (a) building the necessary rapport, (b) creation of an intimate researcher—participant connection, and (c) minimization of the power differentials between researcher and participant (DiCicco-Bloom & Crabtree, 2006).

Data Analysis

Colaizzi's (1978) method was used to guide data analysis. For the purposes of this study, analysis was done with an adapted seven-step method created using Sanders (2003) and Shosha (2012). The seven steps are as follows:

1. Read and re-read descriptions to gather a sense and account of the phenomena as described by the participant.
2. Extract significant statements pertaining to the phenomena.
3. Formulate meanings from the extracted significant statements.
4. Organize the formulated meanings into clusters of themes and emergent themes.
5. Create an exhaustive description using the formulated meanings, themes and emergent themes.
6. Reduce the descriptions by eliminating repeated, misused or overstated descriptions.

7. Return results to participants and incorporate any feedback or additional information into final write up of descriptions (Sanders, 2003; Shosha, 2012).

Step One: Each participant's transcribed interview was uploaded into MAXQDA (qualitative data analysis software) upon return to the researcher. This software was utilized for steps 1 - 4 of the data analysis process. The researcher read the interview of each participant several times (Goldberg & Beitz, 2005; Hindle & Carpenter, 2011; Hycner, 1985; Priest, 2002; Shosha, 2012; Vitale, 2009; Wojnar & Swanson, 2007). The transcripts were read and re-read until the researcher had a complete grasp of the story being shared by the participant. The goal of this process was to gather a sense about the participant's whole experience of the phenomenon being studied (Sanders, 2003). During the process of reading, any emerging thoughts and themes were written down (Sanders, 2003). This step was completed on an on-going basis as interviews were being completed.

Step Two: After the researcher gathered an understanding of the participant's account, significant statements were highlighted, extracted and coded in a table in another document (Sanders, 2003). Significant statements were phrases and statements that related directly to the phenomenon and research questions being studied (Goldberg & Beitz, 2005; Priest, 2002; Wojnar & Swanson, 2007; Vitale, 2009). Only statements relating directly to the experience of sexual and physical intimacy after CSA were extracted from the transcript. Any statement that did not relate directly to the topic was not extracted from the transcript (Hycner, 1985). If confusion about the relevance of a statement arose at any point, the researcher erred on the side of caution and extracted the statement (Hycner, 1985). Extracting significant statements was the first step to

reducing the data and getting a clearer picture of the participant's experience. The goal of this process was to "create a new sense of openness to the data when re-reading it and identify early themes emerging from the data" (Sanders, 2003, p. 295). An example of the table that was used for this step is included below.

Figure 1: Significant Statements

Significant Statements	Transcript Number	Page Number	Line Number

Figure 1: Adapted from "Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher," *by* G. A. Shosha, 2012, *European Scientific* Journal, 8(27), 31.

Step Three: The purpose of this step was to generate meaning from the significant statements. Each statement relating to the experiences of physical and sexual intimacy after CSA was questioned and closely analyzed to determine its' meaning (Sanders, 2003). The goal was to "discover and illuminate meanings hidden in various contexts of the investigated phenomenon" (Wojnar & Swanson, 2007, p. 176) and transform them into phrases using the researcher's own words (Priest, 2002).

In the process of formulating meaning from the significant statements, the researcher engaged in self-questioning, asking the following fundamental questions: (a) What does this mean about sexual/physical intimacy after an experience of CSA? and (b) What does this statement reveal about sexual/physical intimacy (and sexual/physical intimacy in relation to an experience of CSA) (Sanders, 2003)? The context surrounding each significant statement also was questioned to assist with formulating meaning from the statement. All words and phrases before and after the significant statement were

analyzed to ensure the context of the statement was not lost in translation (Hasse & Myers, 1988; Sanders, 2003). All codes generated from the significant statements were placed under a separate category. Figure 2 provides an example of the table for formulated meanings.

Figure 2: Formulated Meanings

Significant Statement	Formulated Meaning

Figure 2: Adapted from "Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher," *by* G. A. Shosha, 2012, *European Scientific Journal*, 8(27), 31.

Step Four: The aim of this step was to cluster the formulated meanings into themes and develop emergent themes from the clusters of themes (Sanders, 2003; Shosha, 2012). This step occurred after all interviewing was concluded and all significant statements for each transcript were coded into themes (Hindle & Carpenter, 2011). The first part of this step involved combining all significant statements that were similar in nature. All significant statements that had a similar structure were clustered together and coded with the theme that united them under the category "Theme Clusters" (Shosha, 2012; Wojnar & Swanson, 2007). This was repeated until all formulated meanings were clustered and grouped together under a theme category. During this process, caution was used to avoid grouping statements under themes too quickly as this could have limited emerging ideas and thoughts (Hindle & Carpenter, 2011). Afterwards, themes were clustered and coded into emergent themes. According to Shosha (2012) "groups of theme clusters that reflect a particular vision issue will be

incorporated together to form a distinctive construct of theme" (p. 39). Theme clusters were placed under one overarching emergent theme under the category "Emergent Themes" (Priest, 2002). Figure 3 provides an example of the table that was used for this step.

Figure 3: Emergent Themes

Formulated Meanings	Theme Clusters	Emergent Theme

Figure 3: Adapted from "Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher," *by* G. A. Shosha, 2012, *European Scientific Journal, 8(27).*

Step Five: This step involved creating a preliminary description of the phenomenon being studied. An exhaustive description of the phenomenon was created (Shosha, 2012). This description was presented as a narrative and integrated all emergent themes, core themes, and formulated meanings (Sanders, 2003). Actual words and phrases provided by participants were included in the narrative. These features were included to enhance the narrative (Shosha, 2012; Wojnar & Swanson, 2007).

Step Six: The creation of the fundamental structure was the aim of this step. This step involved reducing the exhaustive description created in step five. Reduction occurred via elimination of "redundant, misused or overestimated descriptions" from the overall narrative (Shosha, 2012, p. 41). Changes were made to the actual write up of the narrative. Per Shosha (2012), "amendments should be made to generate clear relationships between clusters of themes and their extracted themes, which included also eliminating some ambiguous structures that weaken the whole description" (p. 41).

Step Seven: The final step of data analysis involved returning the product created in step six to participants who agreed to review and comment on the results of the study. This was done to give participants the opportunity to validate the findings of the study (Shosha, 2012). There were four participants who reviewed the preliminary narrative. Of the four participants, one individual gave recommendations for enhancement. Any requested changes were incorporated into the study's final product (Wojnar & Swanson, 2007).

Trustworthiness

Trustworthiness speaks to the level of trust and confidence that can be given to the methodological process and results generated from a study (Carlson, 2010; Koch, 1994; McConnell-Henry, Chapman, Francis, 2009). Thus, a study that uses different methods to create trustworthiness can be considered trustworthy. Per Shenton (2004), a trustworthy study: (a) provides a true picture of the phenomenon being studied, (b) provides a significant amount of information that allows others to determine if the findings are applicable to other contexts, (c) provides a trail that allows another researcher to replicate the study, and (d) proves study findings grown out of the data and not the researcher's own presuppositions (p. 63). The trustworthiness of this study was established through the use of: member checking, debriefing, reflexivity, thick/rich descriptions and an audit trail.

Per Krefting (1991), a study is considered credible when the final product from research participants is recognizable by individuals who have experienced the same phenomena. Member checking is a technique that can be used to ensure final descriptions are accurate reflections of the phenomena being investigated with participants. Carlson

(2010) explains member checking as the opportunity for "members (participants) to check (approve) particular aspects of the interpretation of the data they provided" (p. 1105).

Debriefing sessions can be held with superiors, experts, or peers (Houghton, Casey, Shaw, & Murphy, 2013). These sessions are held to discuss the unfolding process of a study. They are used to determine if there is agreement between the researcher and superior(s) about paths being taken in the research and interpretations being made from the data (Graneheim & Lundman, 2004; Houghton et al., 2013). Essentially, debriefing creates a system of checks and balances that adds credibility to a study.

Horsburgh (2003) defines reflexivity as: "active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation" (Horsburgh, 2003, p. 308). This is a process in which the researcher is transparent about her/his "feelings, uncertainties, values, beliefs, and assumptions" (Carlson, 2010, p. 1104) that could influence interpretations made by readers (Koch, 1994). Reflexivity also can be used to advance thoughts about the data. This is done when researchers use this process to identify any thoughts about emergent patterns and themes from the data (Shenton, 2004).

Thick and rich descriptions are detailed accounts of "culture and context, selection and characteristics of participants, data collection and process of analysis" (Granheim & Lundman, 2004, p. 110); and other rationales made throughout the course of the study to help readers make adequate decisions about the study and its findings (Houghton et al., 2013; Koch, 1994).

An audit trail is a documented step-by-step record of the "methodological and interpretations judgments" (Houghton et al., 2013, p. 14) made by the researcher throughout the course of the study (Shenton, 2004; Carlson, 2010). Thomas and Magilvy (2011) postulate:

> "An audit trail is achieved by (a) describing the specific purpose of the study, (b) discussing how and why the participants were selected for the study, (c) describing how the data were collected and how long the data collection lasted, (d) explaining how the data were reduced or transformed for analysis, (e) discussing the interpretation and presentation of the research findings, and (f) communicating the specific techniques used to determine the credibility of the data" (p. 153).

Debriefing

Debriefing sessions were held with peer advisors during the participant interview and data analysis process. These sessions were used to: (a) gain insight and guidance about the steps being taken in the process and (b) compare emerging codes from the data (Houghton et al., 2013; Thomas & Magilvy, 2011). During participant interviews, the researcher and peer advisors consulted about the questions being used to explore the phenomenon under investigation. While debriefing sessions were used to consult about the interview guide, debriefing primarily was used during the data analysis process. Peer advisors were asked to code transcripts and compare results with the researcher. This process was done for the purposes of obtaining agreement about the way data was coded and sorted, not for the purposes of verification that data has been coded and sorted correctly (Granheim & Lundman, 2004). Following the creation of a preliminary write-up of results, a debriefing session was held with a peer advisor to consult about the findings.

The peer advisor analyzed the study results to determine if a complete picture of the experience was being captured.

Member Checking

In this study, member checking was used to confirm or deny the researcher's interpretations made from the data (Sandelowski, 1993). A preliminary description of interpretations was given to participants who were willing to participate in member checking. Participants were asked to authenticate the proposed interpretations of the data and offer any changes/suggestions that could enhance the results. Member checking occurred with four of the ten participants in the study.

After reading the description, the participant raised dialogue about the past and present sexual abuse among U.S. women of African descent, asking to include information about ongoing pain and sexual abuse of African American women. The other three participants expressed satisfaction with the product as presented.

Reflexivity

Reflexivity was used throughout the process of data collection. For the purposes of this study, the researcher engaged in reflexivity by recording personal feelings, biases, and emergent thoughts about the data in a journal (the most noted method for reflexivity) following each interview (Carlson, 2010; Koch, 1994; Sanders, 2003). Engaging in reflexivity following each interview allowed the researcher to: (a) reflect on the interview process as a whole; (b) release feelings, thoughts, and biases about the whole process; and (c) begin noting thoughts about potential codes.

Thick Descriptions

Thick descriptions were provided for the following: participant demographics, data collection, analysis procedures, and research findings which will be enhanced with "appropriate quotations" (Graneheim & Lundman, 2004, p. 110) to draw readers closer to the story being shared by participants (Carlson, 2010; Granheim & Lundman, 2003; Thomas & Magilvy, 2011). Specific details were provided for these areas in layman's terms. All participants' identifying information was excluded during the write up of the descriptions.

Audit Trail

The audit trail for this study was established using the components described above. In addition, solicitation materials, correspondence between researcher and recruitment sites, audiotaped interviews, journals, transcripts, and documents detailing the analysis process were included in the audit trail (Carlson, 2010). All of these materials were kept in a designated, secured research location in the College of Nursing and Health Professions.

Ethical Considerations

Adherence to the ethical principles: respect for persons, beneficence, and justice were ongoing throughout the course of the research study (Davies & Dodd, 2002; Marshall & Rossman, 2011). According to Marshall and Rossman (2011) ethical principles are: (a) respect for persons: not using participants as a means to an end and respecting their privacy, anonymity, and right to participate or not which is freely consented; (b) beneficence: ensure that participants are not harmed by participating in the study; (c) justice: considerations of who benefits and who does not from the study. This

study adhered to ethical principles by: maintaining confidentiality of participants, using consent form (Appendix B), and specifying inclusion/exclusion criteria to avoid recruitment of vulnerable participants (Israel & Hay, 2006; Orb, Eisenhauer, & Wynaden, 2001; Marshall & Rossman, 2011).

The consent form for this study contained 6 sections: statement of research purpose, selection of research participants, assurance of confidentiality, option to withdraw, description of risks and benefits (Bryne, 2001; Miller, 2008) and compensation (Horsford, 2013). These forms are being stored in a secured (locked) location identified by the College of Nursing and Health Professions for a period of three years and will not be linked to the study's data in any way (Morse & Richard, 2007).

Confidentiality

The confidentiality of each participant was assured in this study. Per Brady, Grand, Powell, and Schink confidentiality of participants can be ensured through the alteration of data (cited in Israel & Hay, 2006). During the interview process, participants were given pseudonyms (chosen by them) to be used throughout the process. Any additional identifying information that could link the participant to the data (e.g., partner's names) was changed to pseudonyms (Orb et al., 2001) for those that desired the change.

Risks and Benefits

Research involving trauma can be very tricky. Some participants may benefit from the process and others may not (Israel & Hay, 2006). For example, Newman, Walker, and Gefland (1999) found a significant amount of participants felt the investigation into the perceptions of women who have participated in research about their

CSA experiences was beneficial while a small portion did not. There were two strategies employed to minimize potential harm in this study: maintaining a safety net of emergency professionals and excluding vulnerable individuals (Israel & Hay, 2006). For the purposes of this study, vulnerable individuals were those who have not: (a) revealed their sexual trauma to their partners or (b) received some level of therapeutic care to address their trauma. A list of individuals and locations that specialize in the treatment of trauma was maintained for use in the event of an emergency (Appendix F). A hard copy of this information was on hand for each interview and participants were supplied an electronic copy as well. There was a strong adherence to the inclusion/exclusion criteria in the recruitment flyer (Appendix A) to assure vulnerable individuals were not included in the study.

Chapter 4: Results

The goal of this study was to gather an understanding of how African American women experience physical and sexual intimacy after they have endured childhood sexual abuse (CSA). Ten African American women between the ages of 26 – 45 were recruited to understand this phenomenon. The demographics for each participant will be presented before the results. Hopefully, providing this information beforehand will assist readers with gathering a complete picture of each participant's story. A breakdown of the analysis process and results will follow the data about the participants.

Christina is a 46-year-old African American, married woman with some college education. Her household income is approximately $50,000 - $70,000. Christina's partner is a 36-year-old African American male with a high school diploma. The couple has been together for eighteen years. Christina was abused on multiple occasions by several different relatives at the age of 5. Christina's partner is aware of her abuse and she received treatment for her trauma at the age of 35.

Diana is a 29-year-old African American, married woman with a college degree. Her household income is approximately $30,000 - $50,000. Her partner is a 36-year-old African American male who has a graduate degree. The couple has been together for two years. Diana was abused on multiple occasions by several different relatives and non-relatives between the ages of 6-11. Diana's partner is aware of her abuse and she received treatment for her trauma between the ages of 18 - 22.

Tiffany is a 33-year-old African American/Hispanic, married woman with some college education. Her household income is above $70,000. Her partner is a 34-year-old African American male with a vocational degree. The couple has been together for eight years. Tiffany was abused on multiple occasions by a non-relative at the age of 13.

Tiffany's partner is aware of her abuse and she received treatment for her trauma at the ages of 16, 19, and 28.

Jennifer is a 28-year-old African American, single, woman with a high school education. Her household income is under $10,000. Her partner is a 45-year-old African American male who also has a high school diploma. The couple has been together for a year and a half. Jennifer was abused on multiple occasions by several different relatives starting at the age of 4. Jennifer's partner is aware of her abuse and she received treatment for her trauma at the age of 8.

Maria is a 30-year-old African American, French, and Puerto Rican, single woman with some college education. Her household income is approximately $10,000 - $30,000. Her partner is a 35-year-old African American male with a high school diploma. The couple has been together for one year. Maria was abused on one occasion by a non-relative at the age of 11. Maria's partner is aware of her abuse and she received treatment for her trauma between the ages of 11-21.

Keisha is a 26-year-old African American, single woman with a college education. Her household income is approximately $10,000 - $30,000. Her partner is a 30-year-old African American male with a high school diploma. The couple has been together for two years. Keisha was abused on multiple occasions by several different relatives at the age of 12. Keisha's partner is aware of her abuse and she has been receiving ongoing informal and formal treatment for her trauma since the age of 24.

Yolanda is a 29-year-old African American, single women with a college education. Her household income is approximately $50,000 - $70,000. Her partner is a 47-year-old African American/Caucasian male with a high school diploma. The couple

has been together for two years. Yolanda was abused on multiple occasions by relatives and non-relatives at the age of 10. Yolanda's partner is aware of her abuse and she received treatment for her trauma at the age of 11.

Candace is a 43-year-old African American, single woman with some college education. The household income was unreported for Candace. Her partner is a 42-year-old African American male who also has some college experience. The couple has been together for seven years. Candace was abused on multiple occasions by relatives before the age of 4. Candace's partner is aware of her abuse and she received treatment for her trauma at the age of 33.

Nae is a 29-year-old African American, single woman with a college degree. Her household income is approximately $50,000 - $70,000. Her partner is a 29-year-old African American male with a high school diploma. The couple has been together for two years. Nae was abused on multiple occasions by a non-relative between the ages of 7 - 9. Nae's partner is aware of her abuse and she received treatment for her trauma at the age of 18.

Torrie is a 37-year-old African American, single woman with some college education. Her household income is approximately $30,000 - $50,000. Her partner is a 46-year-old African American male with a high school diploma. The couple has been together for a little over a year. Torrie was abused on multiple occasions between the ages of 8 - 9. Torrie's partner is aware of her abuse and informal treatment was received at several points in early adulthood.

The analysis of data consisted of a five-step process. Steps one and two were completed with the help of two peer advisors; completion of these steps was done

individually and results were discussed when we rejoined. First, each transcript was read and reread to gather a complete understanding of the participant's story. After an understanding was acquired, statements deemed significant were highlighted and extracted from the transcript. Post extraction, each statement was converted into a meaning unit. In other words, the researcher took the participant's words, pulled the meaning, and turned it into the words of the researcher. This step was done with caution to avoid losing the participant's original statement. There were a total of 150 significant statements extracted and converted (Appendix G). In the next step, similar statements were clustered together and labeled with the theme that united them. Finally, theme clusters were carefully analyzed to determine the ultimate meaning (e.g. what is the story being told) from the data. In the end, nine theme clusters and three emergent themes were produced from the data (Appendix G).

Theme 1: Fragmented early sexual experiences and intimacy following CSA

The first question "How (if at all) do you believe an experience of CSA has influenced your experience(s) of physical and sexual intimacy?" asked participants to reflect on the possible ways their experience of abuse has affected their intimate experiences. The majority of participants expressed the belief that enduring CSA did have an adverse impact on their intimate physical and sexual experiences (Denov, 2004; Vaillancourt-Morel, Godbout, Sabourin, Briere, Lussier, & Runtz, 2016; Clum, Andrinopoulos, Muessig, Ellen, & Adolescent Medicine Trials Network for HIV/AIDS Interventions, 2009; Lemieux & Byers, 2008). The greatest impact could be seen a few years post CSA during early adulthood. The ways in which CSA disrupted intimate experiences during this time frame varied depending on the individual and history of

CSA (Lalor & McElvaney, 2010). For example, some participants abstained from physical and/or sexual intimacy (avoidance) and others engaged in promiscuous behavior with several men. Most participants were able to engage in physical and/or sexual intimacy with a partner, but they experienced an abundance of discomfort and difficulty with intimate interactions. The following is a more in depth look at the negative effects that arise for some women in early adulthood.

Theme Cluster 1: Sexual preference: Older men and promiscuity

Promiscuity was most prominent during mid to late childhood and early adulthood for four participants. For these individuals, promiscuous behavior consisted of multiple sexual partners, sex at a young age, and/or sexual encounters with men who were significantly older. It is important to note participants' own descriptions of their behavior led to the "promiscuous" label. For example, Christina admitted to sex at a young age, "Well, I started having sex at an early age. I wanna say, probably like around thirteen. I feel like, maybe, it (CSA) may have caused me to be, um, maybe a little promiscuous earlier on." Also, prior studies have linked CSA and promiscuity, finding women with a history of CSA are more likely to have: early onset of sex and other related activities (Alexander & Lupfer, 1987; Lodico & DiClemente, 1994; Wilson & Widom, 2008), multiple sexual partners, (Merrill, Guimond, Thomsen, & Milner 2003; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005;Testa,VanZile-Tamsen, & Livingston, 2005.) and involvement in unrestricted and risky sexual activity (Meston, Herman,& Trapnell, 1999; Batten, Follette & Aban, 2001; Vaillancourt-Morel et al., 2016).

Tiffany spoke in great depth about her experience of CSA and how it impacted her early sexual experiences. After enduring CSA, Tiffany had to emotionally and

psychologically rebuild on her own. Due to lack of support and guidance in overcoming the tragedy of CSA, Tiffany resorted to using her body to cope with pain,

> "It affected me before him. Before I let older men touch me because I felt like they liked me or they accepted me or they loved me or something like that because they put their hands on me or they touched me in this way so, I felt loved. So that's how it affected me like with teenage relationships. I mean I was 16 dealing with a 29-year-old man... I just wanted sex because I wanted to feel loved. People I don't remember their names, I couldn't tell you, older men…I can think back to so many situations where I was used just for sex...tell me what I wanted to hear and you may have an opportunity. I had several one night stands and I think back to them (what I do remember about them) because half the time I can't even remember the men."

The culmination of insecurity and desires to feel loved caused Tiffany to engage in meaningless behavior that was void of intimacy. While her actions led to more harm than good, they made Tiffany feel loved and accepted at the time. Promiscuity may have added another layer of trauma for Tiffany, but it helped mask the pain of trauma in the moment.

During her experience of sexual abuse, Maria lost control over her body (Romans, Martin, & Mullen, 1997) to her abuser. Defeated, Maria used promiscuity to regain the control perceived to be lost during CSA. Sex was used as a tool of manipulation and control over the gender that caused the pain in her life, which is not uncommon among this group of women (Clum et al., 2009). Similar to other individuals who developed a

negative view of self after CSA (Niehaus, Jackson, & Davies, 2010; Meston, Rellini, & Heiman, 2006), Maria also used promiscuity to rebuild her confidence and self-esteem,

> "I would see men and I would just go for it. It was the attention from men, which was very, very controlling for me. It was like, "I got to have that." I need to know that you like me: I need to know that I'm attractive."

Maria turned her negative into a positive. Through promiscuity, Maria took back the piece of her that was stolen during her childhood. She used sex in the same manner that it was used against her: to have power and control over another individual.

Promiscuity offered closeness and sex without the involvement of emotions. Per participants, experiences of promiscuity were void of love and real intimacy. All the women shared the sentiment of engaging in promiscuous behaviors mainly for the purpose of feeling love and affection from a male. Everyone possessed the ability to link their behavior to their past experience of abuse.

Theme Cluster 2: Discomfort/Fear

Discomfort (Briere & Elliott, 1994; Denov, 2004) and fear of intimacy (Lisak, 1994; Knight, 1990; Ratican, 1992; Davis et al., 2001) are typical responses after CSA. Most participants described fear and discomfort with early intimate engagements. In this study, individuals were more likely to fear or have difficulty with intimate behaviors that were similar in nature to those endured during their abuse. For example, CSA that involved penetration more often than not led to fear or difficulty with sexual intimacy, but not physical intimacy. At times even the least feared form of intimacy was described as uncomfortable.

Diana spoke in-depth about her difficulty and discomfort with sexual and physical intimacy and how it varied at different points in early relationships. The height of her discomfort occurred before disclosure of her abuse,

> "I wasn't always comfortable with that, I guess, before just before coming out, like to my family about the sexual abuse and everything. And um, I don't know, I just wasn't always comfortable with intimacy... physical intimacy and sexual intimacy."

After disclosure Diana became more comfortable with some intimate behaviors. Despite her ability to participate in some activity, encounters were still unhealthy. In particular, Diana feared interactions that reminded her of the unwanted sexual actions that occurred during CSA. Fear of reliving the abuse or experiencing flashbacks/triggers was the overall cause of Diana's discomfort and/or fear of intimacy (Denov, 2004),

> "It was always a state of fear...during...a lot of fear, during sexual intimacy…I guess what happened to me more frequently was you know, it was the sexual part. So, yeah I think that's why I'm less receptive in that area…I guess it was, I guess experiencing growing up a lot of flashbacks, so, um and I just always thought it always just felt like it was being repeated."

Maria could relate to Diana in the sense that she continuously experienced flashbacks of her past during certain sexual positions. She was able to partake in sex, but positions that were even remotely similar to those experienced during her abuse were triggers,

> "There's one position, I guess a woman is lying face down and the guy lies down too and you're having regular intercourse from the back. I remember for a while it was very hard for me to do that."

Maria and Diana feared the intimate interactions that were similar to behaviors that occurred during the abuse. Engagement in these behaviors triggered reminders of the past, causing them to panic. Even though intimacy was possible (to some extent), fear of returning to that traumatizing period in their youth loomed over them.

A fear of attachment contributed to Torrie's discomfort with physical intimacy. The experience of molestation broke Torrie's ability to trust others, leaving her emotionally unstable. A lack of emotional repair caused Torrie to enter previous relationships with a great deal of anxiety (Meston et al., 2006). She protected herself by detaching from partners, which caused barriers to physical intimacy. Torrie stated, "Just physical touch or getting attached; it's hard for me to be attached to somebody like that, something physical that would kind of attach you to somebody." Torrie also detached from partners because she thought engagement in intimacy was wrong. It appears Torrie never separated consensual from non-consensual behaviors, resulting in the belief that they were wrong as well,

> "As an adult even when I was in other relationships, hugging, kissing, all of those things was kind of like, if I feel those it felt it was something wrong with it. If I did those things I just felt bad about doing it, about getting close to people. So a lot of times in my previous relationships, I used to think it was something wrong. And plus I had detachment issues anyway as far as physical, like I wouldn't kiss certain guys, you know; I wouldn't touch certain guys so it was like kind of something that I just didn't know about."

Diana, Maria, and Torrie made significant attempts to incorporate intimacy in their previous relationships. However, ongoing flashbacks and intrusive thoughts

interfered with their ability to accept and enjoy intimate engagements (DeSilva, 2001). An inability to overcome the past caused these women to approach intimacy with discomfort and fear.

Theme Cluster 3: Avoidance of intimacy similar in nature to CSA

While some participants struggled with intimate engagements, others were completely unable to engage in physical and/or sexual intimacy. There is a high prevalence of intimacy avoidance among those who have been sexually victimized in childhood (Clum et al., 2009; Batten et al., 2001; Vaillancourt-Morel et al., 2016; Staples, Rellini, & Roberts, 2012). Keisha and Candace spoke the most in depth about avoidance and how it impacted their romantic relationships. Both participants entered previous relationships with goals of longevity, but unresolved trauma prevented them from engaging in intimacy. The cause of avoidance was the same for Candace and Keisha: fear of reliving the past (Sigurdardottir, Halldorsdottir, & Bender, 2012; Meston et al., 2006).

"Devoid of context, sex is simply a series of behaviors," (Loeb, Williams, Carmona, Rivkin, Wyatt, Chin, & Asuan-O'Brien, 2002, p. 332). CSA attaches a negative connotation to a human experience that would otherwise be considered un-harmful. Candace is an example of someone who struggled with making the distinction between healthy sex and unwanted sexual contact during CSA. Sexual victimization left Candace unable to have satisfying experiences with sex in her marriage. The willingness was present early on in her marriage, but ongoing flashbacks of the past caused her to become increasingly avoidant of intimacy. Eventually, Candace reached a point where

intimacy (especially sexual intimacy) became so overwhelming that she had to end her marriage,

> "I explained to him some of the moments where I just couldn't bear to be intimate with him and we actually went over why. It was very healing to revisit that past relationship because that was one that I really took to heart when things didn't work out. I would say that was the start of the process of me trying to figure out what is going on with me… that I can't really open up to somebody that I love or that I can push this person away. So yeah, it has impacted how I interact with someone sexually."

The years of penetration during CSA prevented Candace from associating sex with anything other than fear. Even though she was experiencing sex within a mutual and loving relationship, Candace had not reframed her thinking about sex. The inability to engage in pleasurable sexual intimacy caused avoidance and ultimately led to the failure of Candace's marriage.

Following CSA, Keisha abstained from physical intimacy (e.g. hugs) with others to avoid the possibility of re-experiencing harmful touch. Instead of voicing her discomfort with touch, Keisha pushed others away (familial and non-familial) and avoided physical intimacy. Sexual trauma changed the context of touch for Keisha (Jones & Morris, 2007) and heightened her fear and anxiety of revictimization. Keisha explained,

> "I used to hate being touched, but see I grew out of it. Because when I was young, it was my cousin but the way he used to hug me I didn't like it. When I got older, I am not want nobody to hug me because the way he hugged me; I didn't like it.

> So, I didn't want everybody else to try to do that too, so I would just push that all off from everybody. I didn't want no hugs from nobody."

Overcome with fear, Keisha chose to isolate herself from others, especially partners. In Keisha's mind, repelling physical intimacy prevented possible exposure to new trauma. In the end, her lack of openness about her struggle with intimacy led to the downfall of several intimate relationships.

The reactions Keisha and Candace had to intimacy are not unusual. Sigurdardottir, Halldorsdottir, and Bender (2014) described how participants experienced fear as ongoing insecurity and alertness. There was always the expectation that something bad would take place and fear offered protection from the possibility of the unknown (Sigurdardottir et al. 2014). Unlike those who were able to engage in intimacy, deep-rooted injury caused by CSA led to total abstinence of intimacy for Keisha and Candace. The forced engagement in unwanted sexual and physical touch left them distrustful and fearful of intimacy (Knight, 1990).

Theme Cluster 4: Adversity caused by CSA

In addition to struggles with promiscuity, avoidance, and discomfort/fear of intimacy, several participants encountered other relational obstacles that were related directly to their experience of CSA. Some of the issues that arose were: insecurity, emotional turmoil, poor boundaries, self-blame, and a lack of desire for intimacy. These intrapersonal constraints caused interpersonal conflicts(s) that damaged the structure and functioning of romantic relationships. Studies have shown CSA can negatively impact romantic partnerships in diverse ways ranging from issues with infidelity (Colman & Widom, 2004), struggles with emotional communication (Pistorello & Follette, 1998),

low relational satisfaction (Mullen et al.,1994), to sexual disturbance or dysfunction (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia 1992; Seehuus, Clifton, & Rellini, 2015; Kinzl, Trawegar, & Biebl, 1995; Swaby & Morgan, 2009).

After the conclusion of a long-term relationship, Yolanda blamed herself for the infidelity of her ex-partner and the downfall of their relationship,

> "The fact that the last relationship he took it personal, by me never being comfortable with him and eventually I found out he was cheating and I took that personal because I wasn't performing and I was hesitant to do certain things."

Instead of differentiating between all possible contributors (infidelity and adversity caused by CSA) to the end of the relationship, Yolanda held herself responsible for everything. In this cycle of self-blame, Yolanda did not draw a connection between her unresolved trauma and the negative impacts of CSA. Essentially, Yolanda punished herself for not overcoming adversity, which added layers to her battle.

Torrie struggled with setting boundaries around sex with previous partners. There were times when Torrie told herself she would not go beyond a certain point, but ended up breaking these limits and going beyond them. The aftermath of her decision was always an outpouring of emotional turmoil,

> "It's like, okay, I'll have sex but I'm not going to do this, but then I still ended up doing it and then I feel bad about doing it. You understand what I'm saying? I'm cool, but two days later I'm crying, I'm like he don't want me, he not going to call me no more; just things like that. So I go on this emotional roller coaster afterwards. Even if they don't give me that sign, it's just always in the back of my head."

While Torrie willingly went beyond her boundaries in sexual encounters, she experienced internal conflict. It is possible that Torrie's inability to set limits is connected to an unfulfilled desire for love and affection. The unintended sexual encounters that went beyond her limits may have fulfilled her desires in the moment, but in actuality it was just sex without intimacy.

Similar to Torrie, Maria struggled with understanding the proper relationship between sex and love. For years Maria equated sex and physical touch with partners' level of love for her. Whenever Maria did not receive physical and sexual contact, she formulated negative meanings of herself. Maria did not understand that love could be present in the momentary absence of physical and sexual contact,

> "I used to think, 'Well that means you're not attracted to me, I'm not beautiful in your eyes, you don't care for me, and you don't love me'. My ex-husband told me, 'It's not that, I will always love you. You're always #1 in my heart. I want you to start to understand that if a person doesn't touch you or doesn't make you feel sexually satisfied it does not mean they don't love you. It doesn't not mean you're not special to them, they just might not be feeling like that at the time.

Kim, Torrie, and Maria discussed the obstacles they experienced as a result of unresolved sexual trauma. The experiences of these women add volume to the array of relational barriers that arise as a result of CSA. A negative outcome that connects the behavioral processes of these three women is lowered self-esteem, which causes relational dysfunction (Lamoureux et al., 2012). Mayers, Heller, and Heller (2003) speak specifically about "sexual self-esteem" (SSE) and suggest lowered SSE disrupts individual functioning and limits the capacity to develop an intimate bond. The desire to

be in a healthy intimate relationship was present for Yolanda, Torrie, and Maria but low SSE caused problems that prevented comfort and satisfaction with intimacy (Shapiro & Schwarz, 1997).

All the behaviors described above (promiscuity, avoidance, difficulty/fear, and adverse effects) highlight the ways enduring CSA can negatively impact physical and sexual intimacy and relational functioning. These descriptions reflect the difficulties and challenges women face with intimacy after CSA. The culmination of the promiscuity, avoidance, difficulty/fear and adversity theme clusters led to the emergent theme, "Fragmented early sexual experiences and difficulty experiencing healthy intimacy." This theme shows how enduring CSA disrupted participants' ability to cultivate healthy sexual and physical relationships leaving them fragmented in these areas and struggling to achieve some sense of normalcy.

Theme 2: "Healthy/positive experiences of intimacy: Residual effects of abuse present"

The second question "What is your experience of physical and sexual intimacy in your current relationship?" asked participants about their experiences of physical and sexual intimacy within the context of their current relationship. The consensus among participants was that physical and sexual intimacy within the present relationship was healthy overall. Individuals explained how their partners' interactions and communication with them have helped generate enjoyment with gratifying and positive experiences of intimacy. However, participants also described how they continue to face challenges with sexual and physical intimacy with partners proving recovery from CSA is an ongoing process. These challenges are unique to these women in that they are related

to their experience of CSA. Despite setbacks, participants described satisfaction with sexual and physical intimacy and some shared how they are actively working to overcome the challenges they face.

Theme Cluster 1: Positive experiences of intimacy

The way in which one perceives and judges the information they give to another is very important as it shows understanding, validity, and caring which is paramount to intimacy according to Reis and Shaver (1988). The fact that all of the participants described intimacy in their current relationship in a positive light gives credence to the correlation between disclosure and perceptions of the disclosure. Physical and sexual encounters were described as truly intimate given they are shared, desired, and welcomed by the individual. A few participant responses given when asked about the experiences of intimacy in their current relationship were: "I'm comfortable touching, kissing, hugging, lovemaking, and sex, of course. I feel like we both are on the same accord when it comes to our physical and sexual relationship" (Nae); "Just the kissing, the hugging, the rubbing, and everything. Everything he does help make intimacy better for me" (Jennifer); "We hug a lot, we touch each other a lot, it's more intimacy than I ever really had in my previous relationships" (Keisha); "I'm very comfortable with the intimacy in my marriage. The comfort level is a 10; 10 being good" (Christina).

These responses reflect an acceptance and openness for physical and sexual intimacy in ways that were not present in previous relationships. The positive experiences of intimacy seem to not only support the growth of the relationship, but that of the individual as well. Studies have shown partners' perceptions of their relationship as high in quality (Whiffen, Judd, & Aube, 1999) and stable (Henry, Thornberry, & Lee,

2015) protect the individual who has been abused from mental health issues. In the case of the women in this study, feelings of comfort and safety (most noted) with the relationship seem to protect the individual from the relational issues that often arise after CSA.

The feelings of safety and comfort were the factors that contributed to positive experiences of intimacy for Keisha and Diana. After going through physical and sexual violations, Diana is moving into a space of acceptance and comfort with intimacy. She explained how feeling safe has led to the ability to open up and experience intimacy in a more positive manner. In particular, physical intimacy is identified as the easiest form of intimacy for her. Similar to many of the other participants, Diana described comfort with the intimate behaviors least (or not) experienced during CSA. Thus, physical intimacy is preferred over sexual intimacy because it feels safer, "I would say that physical intimacy is easier to experience, and I think the reason that is, um, again, it's a form of safety for me, um a form of reassurance." A baseline of safety and comfort has given Diana the courage to replace her fear of intimacy with openness and acceptance. Considering physical intimacy is easier to experience, her feelings of comfort and safety provide reassurance that touch can be a good thing.

Unlike the past, Keisha feels safe with her current partner, leading to a profound sense of comfort with him. She has allowed herself to open up emotionally and intimately, which is a change from the past,

> "I'm comfortable with our intimate experiences. I think I just jumped in them relationships so I could be in a relationship. I just jumped right into it. I didn't even get a chance to know the person. I didn't get a chance to feel you out or

> nothing. Now this one I've known him 13 years. I know him in and out, left and right, up and down. I can experience physical intimacy in this relationship, but not the others. See, I feel safe with him."

Instead of rushing into a relationship to fill a void, Keisha took the time to learn about her present partner. She acknowledged her negative cycle with males and re-examined how she approaches relationships. The combination of the behavioral change and characteristics of her partner has created an environment that makes her feel secure.

The ability to openly communicate about sexual and physical intimacy has been the contributor to positive intimacy for Tiffany. She discussed the importance of being able to identify and negotiate what makes intimacy enjoyable for her. The ability to have open dialogue around intimacy is crucial for Tiffany given her past. Now that Tiffany is more comfortable with intimacy, she can confidently communicate her sexual needs to her husband,

> "I'm fine with just cuddling. Like showing me that form of intimacy. You have your needs and I have my needs. My needs are more in the present; hold me, rub my hair without it turning sexual."

Disclosure of past trauma has assisted participants with building closeness with partners. In all, participants described physical and sexual intimacy in their current relationships as inherently better than experiences in previous relationships. Factors such as support, security, and open communication have helped the strength and growth of the partnership. These findings are comparable to those found by Nelson Goff et al. (2006) who examined the ways in which one partner's experience of CSA impacts relational dynamics. Among others, Nelson Goff et al. (2006) found partner support and

communication to be vital to the quality and satisfaction of the relationship. Support (in particular) helps participants with the process of learning to reshape their thoughts of physical and sexual interactions.

Theme Cluster 2: Triggers and challenges that negatively impact intimate occurrences

All participants described the intimacy in their current relationship as good, but approximately 80% stated that their past abuse continues to negatively impact functioning within their relationship. Davis, Petretic-Jackson, and Ting (2001) suggest the perception of self and behaviors along with the qualities brought to a relationship are the things that adversely impact a relationship. Thus, individual characteristics and struggles of the participant (abused partner) may be some of the contributors to issues with intimacy. The most frequent causes of dysfunction among the women in this study were ongoing triggers and flashbacks of the past. The intensity and frequency of these issues decrease as the relationship matures, but problems stemming from triggers and flashbacks continue to persist (Clum et al., 2009; Denov, 2004). These ongoing experiences are evidence that recovery from CSA can be a lifelong process. The establishment of a romantic, intimate relationship may lessen adverse effects of CSA, but physical and mental reminders of the past always may interfere with intimacy.

Tiffany provided great insight into how the residual effects of CSA remain present even in the context of a stable marriage. She described physical and sexual intimacy as gratifying within her marriage, but sexual intimacy continues to be a struggle even though the intensity of the problem has decreased over the years. In the beginning of her marriage, Tiffany found herself emotionally breaking down during sex, which

constantly led to a premature termination of the actions. Her growing comfort and feelings of safety with her husband have allowed her to be more accepting and tolerant of sexual intimacy. Despite her progression, flashbacks of the past continue to inhibit her ability to perform oral sex,

> "I enjoy the kissing, I enjoy all of that, the foreplay and everything involved. Something I don't think I've ever expressed to him or told him about is my feelings about me giving him foreplay. I do it because he's my husband and I know he enjoys it, but I think talking about it now, I don't enjoy it. And I think it's because of when my stepfather used to put his penis in my face."

Tiffany's struggle is evidence that residual effects of CSA are present even in an intimately satisfying relationship. Even though Tiffany continues to engage in foreplay, it is for the pleasure of her husband and not her own.

Both Maria and Yolanda share the challenge Tiffany faces in her marriage. They both described their difficulty with intimate interactions that are similar to actions that happened during their abuse. Both women explained that engagement in these behaviors trigger reminders of the past, leading to anxiety and fear (Clum et al., 2009) instead of enjoyment and pleasure. For example, Yolanda described,

> "I think as I became more comfortable it became better, but I think even still now when he go to reach for me, I don't think I recoil as much as I did in the beginning, but I still flinch a little bit sometimes. It's not all the time, but if it catches me off guard, if I'm not sure what his intentions are and he just goes to grab me, I'll flinch a little bit."

Even though Yolanda's comfort with intimacy is growing, intimate interactions that catch her off guard still trigger anxiety. This reaction is connected to her past in that Yolanda continues to mentally and physically associate touch from a male with harm.

Torrie did not report any triggers or flashbacks that inhibit or affect her intimacy, but she did discuss issues with trust and vocalization of her intimate needs. Whenever Torrie's partner inquires about her needs and desires, she finds herself at a loss for words. This inquiry is a new experience for Torrie in that she never felt she had a say in how intimacy unfolded in her previous relationships,

> "When he asks me it's like, 'Huh,' because nobody really asked me what do you want me to do to you, you know? So I'm stumped about that because it was never like that. With my previous relationships it was never about what do you want me to do to you; it was always, 'I want this,' or 'I gotta do this,' or 'I better get this.' It's a little different. I pretty much hold back a lot and I don't believe what the person is saying so it's like you've got to prove it to me. So, it still holds me back from just kind of letting go and being comfortable with what I'm doing."

Torrie's past relationships have left her with the belief that she does not have a say in sex. It is likely that this mindset also stems from her experience of CSA when her voice was silenced. Torrie's present partner has an interest in her intimate desires, but her extensive history of silence causes discomfort with open dialogue about this matter.

The hurdles described by the four women above corroborate earlier findings suggesting the trauma of CSA can extend beyond childhood (Townsend & Rheingold, 2013) and manifest even in healthy relationships. No matter how far these women are removed from the past, it reappears via triggers (Nelson Goff et al., 2006). The passing

of time and relational progress are weakening the effects of CSA, but they nonetheless are present still.

Theme Cluster 3: Process of learning to experience positive intimacy after abuse

As previously stated, several participants continue to battle with the residual effects of CSA even within their current relationship. Despite the ongoing battle with the negative effects of CSA, many are actively working to overcome those issues. Kia-Keating, Sorsoli, and Grossman (2010) propose developing relationship management skills, such as setting boundaries, controlling anger, building trust, and developing intimacy can assist someone with surviving within a romantic relationship during recovery from CSA. The development of such skills reflects the process of learning to overcome the tragedy of the past. It also shows how positive perceptions of one's relationship can help "override or ameliorate fears of intimacy" (Davis et al., 2001).

Similar to others with a past of CSA, fear of sex (Maltz, 2012) was the barrier for Diana. Diana described sex during her abuse as "uncomfortable, fearful, and violating." Now that the sexual abuse has ended, she is learning to enjoy the act of sex. During this process, Diana is learning to reframe her thoughts about sex in order to associate sex with pleasure instead of pain. Her feelings of violation and discomfort are being stripped away and she is working to replace them with feelings of safety and love,

> "I'm learning to just, I guess, enjoy the act instead of what my past was. It was fearful, it was uncomfortable, it was violating. It was, um, I didn't like it, so now being married, where I am comfortable, where I'm safe, where I am loved, it's that part…it's foreign to me. And I'm learning to adjust to it."

Trust is established in a partnership when one feels safe and loved by the other partner; its absence is hazardous for a relationship. Developing the foundation of trust is a major problem for those with a history of CSA (Knight, 1990; Clum et al., 2009). Tiffany spoke candidly about the correlation between learning to trust and developing a positive mindset about intimacy. In order to establish a healthy intimate relationship with her husband, she had to overcome her inability to trust. She had to move past her fear of reliving the trauma and trust that her husband would not re-expose her to harm. The intimacy in her relationship began to blossom once Tiffany gained trust in her partner,

> "Just letting go and just trusting him and that's when it came into play that I had to trust him, to carry on a healthy sexual relationship with him, physical and spiritual. I just had to trust him. Not trust him to make the right decisions but trust him that he would not hurt me."

The emotional, psychological, and sexual harm caused by CSA put Tiffany in a constant state of fear. To maintain a happy marriage, Tiffany had to develop trust in her husband. She had to learn that he would not intentionally cause the same physical and emotional pain that took place during CSA. Tiffany continues to become more trusting of her husband as she heals from her trauma.

According to Romans, Martin, and Mullen (1997), low self-esteem among women who have gone through CSA causes continuous expectations of the worst and feelings of an inability to control events that occur in one's life. For Candace, low self-esteem contributed to her lack of attentiveness to her personal and intimate needs. During and after her experience of CSA, Candace put the needs of others before her own. She negated her desires and needs in relationships with men, ultimately resulting in

dissatisfaction with intimacy. On her path to recovery, Candace is learning the importance of being mindful of her feelings and needs surrounding intimacy. She is more in touch with her boundaries/limits and how they resemble and/or differ from those of her partner,

> "I'm mindful of his feelings; I'm definitely mindful of my own. I don't do anything I'm not willingly ready to participate in doing. I have to actually want to do whatever it is we're going to do sexually or anything so, in a good way. It makes me not take things for granted."

Candace and other participants continue to encounter issues that negatively impact them on an individual and relational level. However, daily attentiveness and cognitive restructuring are assisting them with changing the negative into a positive. Achievement of this shift is largely the work of the individual, but support from intimate partners is a huge contributing factor.

Participants' current relationship offers a new perspective on physical and sexual intimacy. There is growing comfort with the relationship, which is producing positive experiences with intimacy. Disclosure (absent from past relationships for many) has assisted with breaking barriers between partners and facilitating openness and acceptance of sexual and physical intimacy. While the current dynamics of the relationship help with welcoming these forms of intimacy, many participants continue to experience residual effects of CSA. The triggers and flashbacks present prove recovery from CSA is an ongoing journey. The combination of participants' experiences led to the emergent theme, "Healthy/Positive experiences of intimacy: residual effects of abuse present."

Theme 3: "Partner's knowledge assists with creating positive experiences of intimacy."

"Survivors are highly attuned to how others react to the disclosure both at the point of disclosure and at future points in the relationship," (Sims & Garrison, 2014, p.18). The majority of the participants expressed that opening up about their trauma has impacted intimate experiences in their partnership. They shared the belief that their partners' actions and reactions to the knowledge of the abuse have helped them become more accepting of intimacy. This finding reflects how responses and reactions received during and after disclosure of abuse are extremely significant for a survivor (Sims & Garrison, 2014). Eight participants identified things such as support, patience, comfort, and awareness as ways their partners have enhanced physical and sexual intimacy and continue to assist them with embracing consensual physical and sexual encounters.

Theme Cluster 1: Understanding/Patience

The actions of partners labeled most impactful were: patience and having a level of understanding. Six participants identified these factors as influential to their growth with physical and sexual intimacy. The partners of the women exhibit patience and understanding with the challenges that arise, instead of anger and intolerance. The ability to be understanding and empathic has set the tone for the relationship and generated the previously described feelings of comfort and safety with the partner. Diana summed up this process when she described how her partner's actions create an atmosphere that allows intimacy to flourish, "He is very patient, very understanding. Um, not a push a over. Makes it feel very safe."

During reflection of physical and sexual intimacy in her marriage from the past to present, Tiffany elaborated on how issues surrounding intimacy were most prominent before disclosure of the abuse. Intimate interactions with her husband were described as rough in the beginning due to the ambiguity surrounding some of her actions. In particular, her husband did not understand her inability to have sex in certain positions, which led to frustration on his end. The dynamics of the relationship began to shift once Tiffany disclosed her abuse to her husband,

> "He definitely understands. In the beginning he didn't understand, but he understands now. A couple of years ago he used to get upset… He has patience with me. That's how he has affected our experiences of intimacy, because he's very patient with me."

It appears gaining knowledge of the abuse changed the perception Tiffany's spouse had of her sexual avoidance. The lack of awareness about the abuse left her husband with more confusion than answers, creating his frustration. Once he learned the "why" behind her actions, he was able to change his approach and feelings about the intimacy in his marriage. Even if he displays frustration with the functioning of intimacy at some points, he is able to quickly overcome his frustration and be supportive (Nelson et al., 2006).

Before disclosure, Maria and her partner also were unable to see eye to eye on some forms of intimate interactions. These partners were able to resolve their issues once both individuals had a discussion about the importance of establishing boundaries around touch,

> "After I told him about the abuse, we started learning each other's boundaries and that's when the boundary talk came in. That's where it was if I don't feel like doing this, you shouldn't force me to do this. If you don't want a kiss I shouldn't force you to want a kiss. If I don't feel like being touched, I don't feel like being touched."

The identification and implementation of boundaries has improved the quality of physical and sexual intimacy in Maria's relationship. The ability of Maria's partner to respect and accept these limits has been meaningful and impactful to the relationship as a whole.

Theme Cluster 2: Creation of a Supportive Environment

In addition to being patient and understanding, participants identified other factors that reflect support within their partnership. A few of the things that create this supportive environment are: not forcing physical or sexual intimacy, attentiveness to warning signs, open dialogue about intimacy, and assistance with building confidence/self-esteem. Other elements found to be supportive are: positivity, optimism, reassurance, validation, encouragement, and patience (Nelson et al., 2006). These things promote partner awareness of the residual effects of CSA and support with ongoing recovery from this trauma.

An important aspect of intimacy following an experience of CSA is having one's voice heard surrounding intimacy. Physical and sexual intimate interactions that are not forced or demanded are more likely to be welcomed by individuals who have gone through the abuse. Diana spoke to the importance of not being forced into sexual intimacy and how this has affected things with her partner, "He does not force me, which helps me. And what he will do things like hug me; like I have to have physical touch

first." Diana's spouse creates an atmosphere that makes intimacy a choice, not an obligation. He also has a deep understanding of her needs and adapts to ensure he meets these needs. These actions not only reflect support for Diana, but they also show willingness to compromise.

Maria's partner creates a supportive environment by keeping the dialogue open about sex. Before engaging in sexual contact, both partners have a discussion about their level of comfort with the actions that will transpire. This dialogue gives Maria that voice in intimacy proceedings that is critical for someone with her past,

> "Before we even got to intimacy, we used to make sure are you even in the mood? Are you even there, because if you're not there it's no point in doing it? It was one time when he was ready and I was like, 'Oh no, I'm just not. Please don't feel bad, please don't get mad, I'm just not there right now.' He was like, 'No baby, its okay.'

This discussion beforehand serves two purposes for Maria: it shows respect for her level of comfort with intimacy and lets her know that she has control over how her body is touched.

A keen awareness of Tiffany's triggers is how her partner creates a supportive environment. After years of marriage Tiffany's husband is aware of her functioning, including bodily reactions to discomfort. During these times Tiffany's husband can console her and offer support as she overcomes the problem that is causing her to be unsettled in the moment,

> "He's learned to pay attention. He has learned to point out these different things that could possibly trigger me or possibly upset me. He knows how to respond

> to it and how to care for it. Like if he knows I'm up in the middle of the night and he knows I can't sleep or I shake my leg, which I do when I can't sleep, things like that. He'll get up and turn on the light and say, 'Let's talk about it. What is it? What happened? What are you thinking about?'

The response from Tiffany's husband gives her the space to still have adverse emotional and physical reactions and the support necessary to overcome these struggles when they arise. His response also makes recovery from CSA the couple's responsibility and not just Tiffany's.

Laurenceau and Kleinman (2006) argue there are three determinants for intimacy: self disclosure (open communication with a partner), responsiveness (how the recipients of information respond to information given to them), and perceived partner responsiveness (how the disclosing individual perceives the reaction of the partner receiving the information). These three intertwined factors can either build or destroy intimacy in a relationship depending on their presence or absence. For those in this study, self-disclosure, positive partner responses, and perceptions of these responses have created an environment that supports progression. The emergent theme, "Partner's knowledge has helped create positive experiences of intimacy" reflects how collaborative efforts of both partners are creating a foundation that offers stability, growth, and acceptance of the evolving ways of relating to each other through touch and sex.

Participant Outlier

The vast majority of participants had similar experiences with physical and sexual intimacy in the past to present. The bulk of the participants: a) felt CSA did have an adverse impact on physical and sexual intimate experiences, b) described these forms of

intimacy as favorable in their current relationships, c) acknowledged CSA continues to cause issues with physical and sexual intimacy, and d) believe their partner is supportive of their struggles with touch and sex and assists them with overcoming the trauma.However, one participant had an experience that was somewhat different from the others. Nae does not believe her past has impacted past or present intimacy. She expressed, "Personally, I don't feel it has impacted my experiences. I don't reflect back or have any ill feelings. When I'm being touched, I don't think back to the past or anything like that." Within her current relationship, her present partner is described as understanding and supportive despite what she went through in childhood.

While Nae voiced the belief that her CSA has not impacted past or present intimacy, trust was identified as an issue. Nae acknowledged her past has caused inflexibility with trusting others, especially those that are around her daughter,

> "I have like the experience if anything, it didn't personally affect me but it affected who I trust and who I have around my daughter. By me exposing that information to my daughter's father and him knowing, he felt like I was really overbearing of my daughter because of what I experienced in the past. So any little thing I felt like he used that against me… I just wanted to protect her because I wasn't protected."

The overall issue with trusting others is similar to the accounts described by other participants. There may not be a direct correlation between difficulty with trust and relational problems, but it is still present. Nae's struggle with trusting others around her daughter has led to relational disruption and separation due the partner's inability to understand her overprotective nature. So, Nae's experience was different from others in

some respects, but similar in that her history of abuse disrupted intimacy and relational functioning.

Conclusion

Almost all of the participants had an extremely rough start with intimacy in past and current relationships. In early relationships, participants were either promiscuous, avoidant, or unable to maintain a healthy relationship with their partner due to ongoing difficulty with intimate interactions, which ultimately led to the demise and dismantling of partnerships. As the women began to address their trauma and understand how their past can manifest itself in almost every facet of their lives, involvement in a positive, intimate relationship became possible for them. Their partners' sensitivity to the residual effects of CSA has assisted them with the process of becoming open and receptive to intimacy. Even though the participants' journey of recovery from CSA continues in the present, partners show a willingness to walk through this process with them.

Chapter 5: Discussion and Implications

Childhood sexual abuse (CSA) is a worldwide problem that impacts the lives of males and females across all races, ethnicities, and classes. However, the susceptibility of CSA is greater for African American females than any other group of individuals (Perez-Fuentes et al., 2013; Young, et al., 2007; Ullman & Filipas, 2005; Urquiza & Goodin, 1997; Senn et al., 2006). The psychological, emotional, and physical problems that arise after CSA (Townsend, 2013) continue to disrupt functioning well into adulthood for these women.

"Traumatic or untrustworthy experiences which create severe stress may negatively affect the development of intimacy" (Lees, 1993 p.2). The data from the women in this study are evidence that an experience of CSA can cause devastating and unhealthy intimate functioning in adulthood. Approximately 90% of the women in this study expressed beliefs that enduring CSA has affected past and current intimate functioning in some fashion. This is not a new finding given individuals with a history of CSA are likely to report issues with infidelity (Colman & Widom, 2004), struggles with emotional communication (Pistorello & Follette, 1998), low relational and intimate satisfaction (Mullen et al., 1994), and sexual disturbance and dysfunction (Beitchman et al., 1992).

Despite reports of disrupted physical and sexual intimate experiences, all participants shared positive accounts of intimacy in their current relationships. The ability to identify positive experiences of intimacy speaks volumes for these African American women given their past trauma. Findings from this study prove African American CSA survivors have desires for fulfilling, intimate relationships with male

partners. Additionally, collected data on the length of participants' relationships show these African American women strive to obtain and maintain marriage. The information from this study support claims that African Americans value and seek marriage (Curran et al. 2010). Marital rates (Chambers, & Kravitz, 2011; Tucker & Mitchell-Kernan, 1995) and satisfaction (Corra et al., 2009) may be low among African Americans as a whole, but findings from this study reflect hope for African American women, especially those who have endured CSA.

This study is unique because of its focus on African American women's perceptions of their partner's role in recovery from CSA and partner behaviors that enhance this process. Other studies (Goff, 2006 and Smedley, 2012) that have examined partners' role in recovery from CSA have largely done so with Caucasian CSA survivors and partners. This study is also unique due to its exploration into how a partner's characteristics influence physical and sexual intimacy. Prior studies have not explored the partner's role in a specific form of intimacy. This study narrows its focus to physical and sexual intimacy making the findings unique to these forms of intimacy.

There were three main themes that emerged from this study: a) CSA does have a negative impact on sexual and physical intimate interactions and behaviors in early adulthood, b) positive experiences of sexual and physical intimacy are possible in the context of a stable and loving relationship after CSA, and c) partner's awareness of the abuse positively does influence how sexual and physical intimacy is received and reciprocated. This chapter will expand on the findings of the study, discuss the limitations, and connect results to clinical treatment with this population of African American women.

Abuse Severity

Browne and Finkelhor (1986) were among the first to examine the correlation between severity of abuse and long-term effects in adulthood with results showing a direct connection between abuse factors (e.g., perpetrator, genital contact, and force) and future symptoms. Since this early study, other factors have been used to measure abuse severity. The duration and frequency of the abuse (Feinauer, Mitchell, Harper, & Dane, 1996), relationship to perpetrator (Myers, Wyatt, Loeb, Carmona, Warda, Longshore, Chin, & Liu, 2006; Lees, 1993; Watson & Halford, 2010), and age of onset (Pistorello & Follette, 1998) are commonly used to measure severity of abuse.

Studies show African American women are more likely to experience penetration (Lestrade et. al., 2013; West, 2002), frequent occurrences of abuse (Wyatt, 1985**),** and abuse within their homes (Amodeo et al., 2006). The correlation between severity of abuse and negative consequences was not measured in this study, but relationships between the two were discovered. Data analysis showed participants were more likely to experience intrafamilial abuse (abuse within the homes), frequent abuse (more than one occurrence), and abuse by more than one perpetrator. An examination of the data using a Computer Assisted Maltreatment Inventory (CAMI) developed by DiLillo et al. (2010) shows participants would score in the severe range on four of the six dimensions. These findings offer an explanation for why interpersonal dysfunction began at a young age for many of the women in this study and persist even now in their current partnerships.

Promiscuity

A few participants engaged in promiscuous behavior a few years after CSA, which is a residual effect of CSA (DiLillo, 2001; Dube et al., 2005; Fergusson & David,

1997). For the purposes of this study, promiscuous behavior of multiple sexual partners, sex at a young age, and/or sexual encounters with men who were significantly older. Ongoing struggles with emotional attachment (necessary to build intimacy) and attempts to regain control (Clum et al., 2009) are two factors that have been linked to promiscuity among those who experienced CSA.

All of the participants who exhibited promiscuous behavior had similar reasoning for their actions. In a nutshell, desires to feel loved and wanted by males were the main contributors to promiscuity. Participants were able to label their behavior as risky and describe how their actions have negatively impacted them. CSA emotionally and psychologically affected these women, leaving them feeling unworthy of healthy, trusting sexual and physical bonds with men. While risky sexual behavior led to dysfunction, it also fulfilled unmet needs. The behavior provided the desired physical and sexual affection without the emotional attachment that accompanies partnerships (Batten et al., 2001). The high prevalence of distrust (Briere & Elliott, 1994**;** Knight, 1990) among these individuals causes an inability to establish healthy partnerships, making promiscuity a viable alternative.

CSA strips the victim of control over human functioning **(**Romans et al., 1997**),** creating a cycle that has the potential to only spiral downward. Ongoing exposure to traumatic experiences without disclosure decreases feelings of control over life. After the abuse has concluded there is a fight to regain balance and control. This can be done with the use of maladaptive practices such as promiscuity. Clum, Andrinopoulos, Muessig, Ellen, & Adolescent Medicine Trials Network for HIV/AIDS Interventions (2009) suggests promiscuity is likely after CSA because the behaviors provide a sense of power

and control over the areas of life that have been impaired as a result of the abuse. Promiscuity assists with reversing a negative view of self (Niehaus et al., 2010; Meston et al., 2006) via building confidence and counteracting feelings of perceived weakness. Others may view multiple sexual partners and sexual acting out as unhealthy (even taboo), but some women who have experienced CSA may view this behavior as empowering. For example, one participant linked promiscuity with a restoration of power. Despite only one participant directly connecting promiscuity to regaining a sense of power, it may be that other participants who engaged in promiscuous behavior also sought to reclaim power and control.

Avoidance

Merrill, Guimond, Thomsen, and Milner (2003) predicted women who have endured severe CSA would respond to relational functioning in one of two ways in adulthood: self-destructive coping via dysfunctional sexual behavior and large numbers of sex partners or avoidant coping possibly causing sexual concerns and a small number of sex partners. Avoidance of intimacy can look different for each individual. For example, some individuals may avoid a particular type of intimacy and others may avoid all forms of intimacy. Approximately 75% of the women in this study avoided physical and/or sexual intimacy in some form before their current relationship. There was either a total avoidance of intimacy or avoidance of intimate behaviors similar in nature to the actions that occurred during the abuse.

Helplessness and powerlessness are two words that capture the totality of how participants felt during and after their experience of CSA. For example, Diana's fear of any form of touch left her crippled and confined, "It was always a state of fear also, um,

during a lot of fear, during sexual intimacy, and I did not partake in, um, physical intimacy. I didn't like massages, I didn't like hugs, didn't like to be touched." The experience was so damaging for Keisha that all physical interactions with individuals had to end, even those who had not victimized her were distanced, "After the abuse everybody was just cut off with hugs and I didn't hug nobody… I didn't want no physical contact. We could speak, but I wouldn't even be in the room with a male figure, not by myself." Their fears and concerns of possibly returning to this undesired place caused avoidance of intimacy.

Their fears and concerns of possibly returning to this undesired place caused avoidance of intimacy. Experiential avoidance is "a process in which a person is unwilling to experience negatively evaluated private events, such as thoughts, feelings, or memories, and thus makes subsequent attempts to reduce, numb, or alleviate those experiences" (Batten et al., 2001, p 102). Participants in this study sought to reduce or prevent flashbacks and intrusive memories of the past CSA through avoidance of intimate interactions. Avoidance of intimacy offered protection from distress and post-traumatic stress symptoms but it caused distance between partners (Clum et al. 2009), which is a drawback. The women who avoided intimacy encountered multiple issues with mates (e.g. disagreements about sex, unwillingness to accept physical affection) and ultimately their relationship fell apart. Avoidant behaviors addressed the covert issues, which were fear of revictimization and associated feelings. However, problems pertaining to the inability to maintain a partnership were left unresolved.

Discomfort/Fear

As a result of broken defenses in early life, women who have experienced CSA are likely to live in fear of the possibility of something bad happening to them (Sigurdardottir et al., 2014). The world appears to be scary and unsafe following the abuse, which complicates interpersonal functioning. Discomfort and fear were the most common responses to the explored forms of intimacy among the participants. This finding suggests commitment and engagement in intimacy are possible after CSA, but engagements are uncomfortable (and sometimes scary) for the individual. Discomfort and fear of intimacy, men, and partnerships help to explain why sexual dysfunction and disturbance is common (Beitchman et al., 1992; Niehaus et al., 2010) among this group of women. As was the case with avoidance of sexual and physical intimacy, participants described greater discomfort and fear of intimate interactions that were similar to previously experienced harmful behaviors. Although sex and physical touch are possible after CSA, the participants' stories of fear and distress document the complexity and difficulty involved in sexual relating and intimacy.

Relationships

The findings from this study suggest physical and sexual experiences of intimacy are most difficult immediately following the termination of the abuse. As described by participants, feelings of confusion, fear, discomfort, anger, etc. all collide and adversely impact intimate occurrences. Thus, romantic relationships established in early adulthood are less likely to survive.

Despite adversity, some individuals can reach a level of comfort with partners, which makes sexual and physical exchanges bearable and enjoyable. During the process

of recovering from CSA, negative experiences of physical and sexual intimacy decrease and positive ones emerge. This was evidenced by participants' positive descriptions of relational and physical/sexual intimate functioning in current partnerships in comparison to previous ones. Everyone expressed satisfaction with the relational dynamics and overall functioning of the relationship was perceived as positive. According to Whiffen, Judd, & Aube (1999), survivors of CSA are less likely to experience depression when they view their current relationship as high in quality. This suggests positive, intimate relationships have the potential to enhance growth of those with a history of CSA during the process of recovery. The relational partnerships of the women in this study provided support, nurturance and a sense of sexual, physical, and emotional security. There were two factors that assisted with participants' openness to physical and sexual intimacy: disclosure of abuse and establishment of trust.

Disclosure of past trauma and development of trust in a male were two things that did not always occur in previous relationships. After CSA, individuals had to relearn the meaning of intimacy by reframing their thoughts about touch and sex in order to become comfortable with these things. Birnie-Porter & Lydon (2013) suggest trust is the most important component of intimacy, but the establishment of trust is a highly difficult task for those who have endured CSA (Bacon & Lein, 1996; DiLillo, 2001; DiLillo & Long, 1999). The experience of having your space invaded and violated leaves wounds that could take years to heal. Given the struggle with trust, it is remarkable when someone who has gone through the tragedy of CSA becomes vulnerable enough to permit intimacy of any form. Along with granting permission to receive physical and sexual affection is the ability to be open about events that have distorted perceptions of interpersonal

relationships. Disclosure aids in the process of healing (Del Castillo, & O'Dougherty-Wright 2009) by allowing one to be set free (Sigurdardottir et al., 2012) from the pain and restrictions caused by the past. Disclosing CSA to one's partner created stronger relational bonds for the majority of participants.

By disclosing CSA, participants demonstrated faith in their relationships and entrusted partners to be able to hold their struggles and work through any ensuing issues. For these women, the decision to disclose CSA to their partners has led to gratification in physical/sexual intimacy and overall relational functioning. Participants had extraordinary things to say about their current relationships and express satisfaction with physical and sexual engagements. This is evidenced by statements such as, "It is a lot different. We hug a lot, we touch each other a lot, it's more intimacy than I ever really had in my previous relationships," (Keisha); "We are still attracted to each other. We still turn each other on. We still enjoy being intimate with each other. So I feel like that makes it very good especially after 20 years I feel like the intimacy is more like great," (Christina); "He has patience with me…he's very patient… He may not get it at the time….but once he thinks about it or we'll talk about then it puts it into perspective for him and he does understand where it stems from," (Tiffany). The main contributors to satisfaction are feelings of safety and comfort with their partner, which extend to physical and sexual intimacy. Unlike past experiences, physical/sexual intimacy is not avoided, feared, or done to fill a void. It is genuinely welcomed and reciprocated.

The dynamics of the current relationships certainly help improve physical and sexual intimate functioning for participants, but adversity is still present. There were several statements made about the ongoing experience of triggers and challenges even

within the context of the current relationship. Yolanda, for example, explained how she continues to be uncomfortable with intimacy at times, causing disappointment in herself,

> "I'm kind of disappointed in myself sometimes when my boyfriend he goes to touch me, hug me, any kind of intimacy and I back away from it because I feel like right now I should be past this. I do trust him. I trust him with my life. I trust him with my son and I feel like it shouldn't bother me this much and I am disappointed in myself that I can't receive it."

Maria described a similar problem in that unexpected touch triggers a flight-or-flight response. She described an incident that turned violent when she would caught off guard by her boyfriend, "I remember having a flashback washing dishes. My boyfriend just came to give me a kiss…. I blanked out. I turned and smacked him and we tussled." Maria's boyfriend meant no harm (which she understands), but her inability to remove the abuse from her mentally puts her on constant edge.

Tiffany discussed the flashbacks she experiences when she provides her husband with

> foreplay," "Something I don't think I've ever expressed to him or told him about me giving him foreplay. I do it because he's my husband and I know he enjoys it, but I think talking about it now, I don't and I think it's because of when my stepfather used to put his penis in my face." This experience may not outright impact Tiffany's interactions with her husband, but it does cause her to be unsettled internally.

Reactivation of the trauma of CSA reflects the life long process of recovery. Even though several women in this study have not arrived at a point of total satisfaction and

comfort with physical and/or sexual intimacy, they are continuously striving for intimate health.

Partners Awareness

Strong contributing factors to the shift from negative to positive intimate experiences were the characteristics of the partner. The women in this study spoke highly of their partners and the support they offer to them. Partners are credited for assisting with the process of recovery from CSA through patience and creation of a supportive environment. As mentioned by a few participants, previous partners were unsupportive and unable to understand the severe impact of CSA on the dynamics of intimacy. The survival of the current relationship suggests partner characteristics play a crucial role in building a foundation that will allow physical and sexual intimacy to flourish given the woman's experience of CSA.

Unforeseen Outcomes

All except one of the participants had some form of adverse reaction to sexual and physical intimacy following CSA. There was one individual who did not feel her past had a negative impact on physical or sexual intimacy occurrences within any of her romantic relationships. This one exception is evidence that CSA affects individuals differently in adulthood (Gregory, 2014). Some individuals are unable to cope with life experiences (e.g. romantic relationships) as a result of their past and others are unscathed (or appear unscathed) by their past trauma. It is unclear why the experience of this individual was different from others in the study. However, differences in familial dynamics among participants offer a possible explanation.

Alexander & Lupfer (1987) found women with a history of CSA are less likely to come from a family that is cohesive or adaptable which is reflective of the findings in this study. Of the ten women in this study, eight identified some additional form of dysfunction (in addition to sexual abuse) within their home. Physical abuse, emotional neglect, abuse in foster care, parental addiction, and abandonment were among those described by participants. The high prevalence of co-occurring trauma comes as no surprise given that CSA and other familial dysfunction in childhood often go hand in hand (Felitti, et al., 1998). Unlike the other participants, familial dysfunction was not present for the one individual who has not encountered adversity related to physical or sexual intimacy in adulthood. In fact, she described how she received tremendous family support following disclosure of her trauma. This supports Lalor & McElvaney's (2010) claim that familial support is a determinant for short and long term effects of CSA. It is possible familial support functioned as a buffer, allowing interpersonal relationships to thrive without constriction or deficit. Lees (1993) argues that the absence of attachment, connection, acceptance, and trustworthiness could jeopardize a child's ability to connect with others. Instead of enduring adverse sexual and physical intimate experiences, openness and appreciation for shared interactions modeled in childhood make such intimate experiences possible in romantic relationships.

Limitations

In qualitative research, "the aim is to make logical generalizations to a theoretical understanding of a similar class of phenomena rather than probabilistic generalizations to a population" (Popay, Rogers, & Williams, 1988, p.348). Given the importance of producing reliable results, participant selection for this study had to be precise and

heavily scrutinized. The tight participant criteria resulted in the production of a small sample size. The small group created the highest probability of data accuracy, but makes generalizability to the larger population complicated. The goal of this study was to examine the relationship between CSA and physical and sexual intimacy from the views of African American women. Considering this study focused specifically on African American women with a history of CSA, caution should be taken when applying the results to women from other racial and ethnic backgrounds. Additionally, individuals should be cautioned about drawing correlations between findings about CSA and other forms of abuse as results may differ. The results yielded from this study may not apply to a wide range of individuals, but they help to understand the devastating impact of CSA in romantic, interpersonal relationships of African American women.

The similarities among participants' experiences with current partners are also a limitation of this study. All ten women who agreed to participate in this study shared positive experiences of intimacy within their current relationship. This common feature shows a particular type of CSA survivor was attracted to the study. It is possible all the women agreed to participate in this study because of their level of satisfaction and comfort with their partner and relationship. As suggested by Whiffen et al. (1999), it is possible these women represent a subset of victimized women who are healthier than others who also have experienced CSA. This is supported by the fact that all participants have received some form of therapeutic treatment in the past. The ability to seek treatment and engage in dialogue related to the trauma of CSA demonstrates some level of psychological and emotional health. Additionally, all participants had positive experiences with sexual and physical intimacy after disclosing their abuse to their

partners. Thus, it is likely that only women who had positive experiences after disclosure were drawn to the study. A lack of diversity among participants does not reflect the experiences of women who may be in distress (Whiffen et al. 1999), which causes relational descriptions that do not cast their partnership in a positive light.

The limited number of interactions with participants is also a limitation of this study. Apart from the four that participated in member checking, only one meeting occurred with participants. This means participants only had one chance to divulge information about the topic being explored. While participants provided great insight into their experiences, it is unknown how much other information could have been obtained if several interactions occurred with them. Additional meetings with participants could have led to more depth and clarity about their experiences enhancing the final description of the phenomenon.

Clinical Implications

The findings from this study are evidence that some reactions among African American women post CSA may be similar to those of women from other races and ethnicities. Similar to others, African American women also experience avoidance, fear, discomfort, and promiscuity in adulthood. However, African American women also must grapple with residual effects of slavery that include transgenerational and historical sexual trauma. African American women's unique and extensive exposure to sexual victimization requires specialized clinical treatment and strategies that take past and present factors into consideration. Two things that should be considered when providing treatment to this specific group of women are: a) historical sexual abuse among women

of African descent in the U.S. and b) relational dynamics between African American women and men dating back to slavery in the U.S.

Unlike other women, African American women with a history of CSA are potentially left with damage from individual and transgenerational sexual trauma (historical trauma). Transgenerational trauma is defined as historical and ongoing traumatic experiences that affect more than one generation (Crawford, Nobles & DeGruy Leary, 2003; Dass-Brailsford, 2007). While not purposely explored in this study, three women acknowledged the historic sexual trauma of Black women in U.S. and how this trauma dually impacts present intimate issues. In sum, participants discussed the importance of not ignoring historical sexual trauma and incorporating knowledge of this trauma into treatment with African American women who have gone through CSA.

Yolanda, for example, expressed beliefs that African American women suffer from permanent dysfunction with intimacy given they never seem to escape the tragedy of sexual abuse,

> "No one will ever truly understand the pain of Black women. We have been going through this for years, centuries, decades. We can work on getting better with intimacy, but we are never going to truly run right because we keep getting raped and molested."

Candace spoke to the importance of raising awareness about historical sexual trauma during clinical treatment of intimacy problems,

> "My words to others is to study yourself, study sex energy, and to study the plight of your people, what we have gone through as a people and it will help us to overcome the issues that we have with intimacy."

O'Driscoll & Flanagan (2016) found clinical treatment that focused exclusively on treating psychological issues (e.g. depression, PTSD, etc.) after CSA does not address the sexual problems that arise. In the case of African American women, treatment should focus on historical and present issues that contribute to sexual problems. The extensive exposure to sexual victimization among Black women requires putting a special emphasis on the struggles, ideals, and attitudes of African American women (Marble, 1983). Resiliency, is a trait commonly found among African American women (Wright, Perez, & Johnson, 2010; Charney et al., 2008; Todd & Worell, 2000), which could be used to weave the dialogue about historical trauma into clinical treatment with African American female survivors of CSA. If utilized correctly, practitioners could use resiliency to highlight the strength, capabilities, and their overall importance as human beings.

Those women who are seeking therapeutic services for relationship discord could benefit from treatment that focuses on intrapersonal and interpersonal issues. The ongoing matters that persist even within the context of a seemingly stable relationship demonstrate the need for treatment that examines problems relationally instead of individually. An examination of how intimate issues and processes impact the functioning of the relationship from the views of both partners is most important for African Americans. The intimate processes between African American women and men have been convoluted since slavery. Slavery sought to damage the strength of love and intimacy between Black men and women by controlling sexual experiences and physical separation of partners (Lawrence-Webb et al., 2004). The devastation Black men and women faced during slavery was meant to destroy any possibility of long term intimacy

between African American men and women. Enslaved women may have endured most of the sexual victimization, but enslaved men had to bear witness and/or participate in these tragedies. They had to watch as their partners were victimized in foul ways, causing distortion of consensual intimacy. Thus, male partners should not be excluded from therapeutic processes. Incorporation of male partners and discussions of how past adversity between Black men and women impacts current intimate functions has the potential to restructure intimacy between partners and allow new patterns to emerge.

This study opens the gateway for several other future research opportunities. One future recommendation would be to conduct a cross cultural study to determine if the findings of this study compare with the experiences of women from other backgrounds. This analysis could help decipher if past and present experiences of physical and sexual intimacy post CSA are similar or different for women from various races and ethnicities. In conjunction, a within group examination of experiences could help determine if other factors (e.g. education, income, age) play a role in intimacy processes in adulthood.

"Resiliency is defined as the ability to withstand and rebound from adversity" (Stokes, 2014). African American women possess the ability to navigate through some of the toughest obstacles placed in their way making them extremely resilient. Even when survival seems impossible, African American women seem to find a way to rise above it all. African American women who can forge healthy, intimate relationships even after enduring CSA display a level of resilience. The possible negative outcomes (e.g. emotional, psychological, physical disruption) stack the odds against anyone who has endured CSA. African American women are up against even greater odds given the added factor of historical sexual trauma. The underlining factors driving their ability to

overcome adversity is unknown. The ability to build a healthy, romantic relationship that contains physical and sexual intimacy displays resiliency. Additional research is needed to help understand what processes help build the resiliency factors among African American women who can achieve relational and intimacy stability after CSA.

Religion and spirituality play a key role in the lives of African American women (Conway-Phillips & Janusek, 2016; Taylor & Chatters, 1986 in Holt, Lukwago & Kreuter, 2003); they "act as irreplaceable supports to the sanity of Black women" (Eugene, 1995, p.69). Religious/spiritual beliefs were not explored with participants in this study, but a few did refer to "God" suggesting a belief in a higher power. This mention shows higher belief systems may play a role in the everyday decision making and functioning of some African American women with a history of CSA. A good angle for future research would be exploring how religion/ spirituality is used as a resource in decision making about sexual and physical intimacy and romantic relationships after disclosure of CSA.

Some women raised the topic about race and how it relates to the phenomenon under investigation during the course of this study. In particular, dialogue surrounded the historical sexual trauma among Black women in America and how this ties into intimate functioning and CSA among African American women. A more in depth understanding of African American women's views on this matter is a final recommendation. This exploration would provide insight into African American women's perceptions on the connection between historical and current sexual trauma and intimacy. It is possible some women may see a connection and others may not, but raising the dialogue could help bridge the gap between the past and present trauma and how both impact present

functioning of African American partners. Additionally, it could help create a roadmap for how to therapeutically untangle the complexities of trauma and intimate dysfunction among African American women and begin the healing process.

Larsen, Sandberg, Harper & Bean (2011) concluded CSA is not a risk factor for relational functioning, but a considerable amount of research suggests the contrary. Others have discovered CSA is a risk factor for partnerships, causing issues such as relationship dissatisfaction (Liang, Williams, & Siegel 2006), martial distress (Godbout, Sabourin & Lussier, 2009) and sexual dysfunction (Davis Petretic-Jackson & Ting, 2001) to name a few. The potential harm CSA poses for a relationship signifies the importance of exploring the current phenomenon from the perspective of both partners. This study explored the dynamics of physical and sexual intimacy solely from the viewpoint of the female who also happens to be the victimized partner. Incorporation of views and opinions from both partners could lead to a more complete conceptualization of how CSA impacts the intimacy functioning of both individuals and the dyad. This is of extreme significance for African American partners given the ways trauma has been impacting intimacy between men and women of African descent since the start of enslavement in the U.S.

The exploration into the relational processes from the perspective of both individuals in the dyad is an important piece of the puzzle, but exploring why male partners are willing to enter relationships with women who have experienced CSA takes thing to a deeper level. The "why" behind a partner's decision to remain in an intimate relationship after learning the truth about CSA is unknown. Bacon (1996) found hope for change and strong familial beliefs as contributors to partners' desires to remain with

their partner after disclosure. However, additional information still needs to be gathered from these partners. A more in depth examination into the internal workings of non-victimized male partners could help with understanding their motivation behind the decision to stay with abused partners. This examination could include analysis of personality traits, mental and emotional stability, and possible experiences of exposure to trauma.

Lastly, exploration into the adult attachment styles of both partners is a recommendation for future research. The attachment style of adults speaks volumes to how an individual operates within the context of a romantic relationship. "Attachment theory proposes that early relationships between children and their caregivers shape the development of children's "internal working models" of self and others," (Whiffen et al. 1999). It is suggested that children with a history of CSA have fearful/avoidant attachment styles (MacIntosh & Johnson, 2008) creating "difficulty forming secure, intimate, non-abusive relationship," (Whiffen et al.1999). Some women in this study did exhibit fearful/avoidant attachment styles causing the intimacy problems in early adulthood. However, participants were able to shift their approach to relationships leading to the development of a healthy partnership. The factors allowing this transformation is a mystery creating the need for additional research. For partners, exploration into adult attachment style may help understand the differences between those who choose to stay with women who have endured CSA and those who were unable to remain in the relationship.

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Appendix A Recruitment Flyer

Drexel University
Recruiting Volunteers for a Research Study

Research Title:

Experiences of Sexual and Physical Intimacy from the Voices of African American Female Childhood Sexual Abuse (CSA) Survivors: A Phenomenological Study

Research Objectives:

The purpose of this study is to explore and understand African American women's experience of intimacy in their current relationship after going through childhood sexual abuse. This study will focus specifically on exploring and understanding sexual and physical intimacy. The researcher hopes to use this study to provide therapists and others who work with child sexual abuse survivors information on how an experience of CSA affects physical and sexual intimacy in African American relationships. An individual interview will be conducted with you in-person or via phone. Participation in the study will last for 2 hours one day and 1 hour on another day for a follow up to the study. In-person interviews will be conducted in a private location of your choice. However, in-person interviews will only be granted for locations in the Philadelphia area.

Information for Research Subjects Eligibility

You can participate in this study if you: (a) are an African American female, (b) between the ages of 25-45, (c) currently involved in a relationship with a male, (d) heterosexual, (e) have been in the relationship with this male for at least one year, (g) have told your partner about your experience of abuse, and (h) have received therapeutic treatment of some sort for the abuse you experienced.

Remuneration

If you agree to take part in this research study, we will pay you $25.00 in the form of a gift card. The gift card will be given to you immediately after your first interview is complete.

Location of the research and person to contact for further information

This research is approved by the Institutional review board.

If you are interested in participating in this study, please contact::

Allena M. Moncrief, M.A. (267) 696-0696

This research is conducted by a researcher who is a member of Drexel University.

Appendix B Drexel University Consent Form

Drexel University
Consent to Take Part
In a Research Study

1. Title of research study: **Experiences of Sexual and Physical Intimacy from the Voices of African American Female Childhood Sexual Abuse (CSA) Survivors: A Phenomenological Study**

2. Researcher: **Marlene F Watson, Ph.D., LMFT, Principle Investigator and** *Allena M. Moncrief, MA, Co-Investigator.*

3. Why you are being invited to take part in a research study

We invite you to take part in a research study because you: (a) are an African American female, (b) between the ages of 25-45, (c) currently involved in a relationship with a male partner, (d) heterosexual, (e) have been in the relationship with this male for at least one year, (g) have told your partner about your experience of abuse, and (h) have received therapeutic treatment of some sort for the abuse you experienced.

Your participation will help us gain an understanding of how African American women deal with experiences of intimacy after going through childhood sexual abuse. The information you provide could help other African American women with the same experiences overcome some of the same challenges you may have faced. Therapists would be able to take your feedback and give other African American female survivors of CSA help with intimacy in their relationships. This in turn could help build stronger relationships between African American women and men.

4. What you should know about a research study

- Someone will explain this research study to you.

- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part now and change your mind later.
- If you decide to not be a part of this research no one will hold it against you.
- Feel free to ask all the questions you want before you decide.

5. Who can you talk to about this research study?

If you have questions, concerns, or complaints, or think the research has hurt you, talk to the research team via email or phone: mfw24@drexel.edu/ (267) 359-5522 (Marlene F. Watson, PhD, LMFT) or amm494@ drexel.edu/ (215) 696-0696 (Allena M. Moncrief, M.A.).

This research has been reviewed and approved by an Institutional Review Board (IRB). The IRB reviews research projects so that steps are taken to protect the rights and welfare of human subjects taking part in research. You may talk to them at (215) 255-7857 or email HRPP@drexel.edu for any of the following:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get information or provide input about this research.

6. Why are we doing this research?

The purpose of this study is to explore and understand African American women's experience of intimacy in their current relationships after going through childhood sexual abuse (CSA). This study will focus on exploring and understanding sexual and physical intimacy. The researchers hope to use this study to provide therapists and others who work with child sexual abuse survivors information on how an experience of CSA affects physical and sexual intimacy in African American relationships.

7. How long will the research last?

We expect that you will be in this research study for 2 hours on one day for the initial interview and 1 hour on another day for a follow up to the initial interview.

8. How many people will be studied?

We expect about 5-10 people will be in this research study.

9. What happens if I say yes, I want to be in this research?

An individual interview will be conducted with you in-person or on the telephone. In-person interviews can be conducted in a private location of your choice. However, in-person interviews will only be granted for locations in the Philadelphia area. The interview will be recorded by the researcher with an audio-recorder. The interview could take up to about two hours. After the interview, you will be asked if you would like to participate in a second meeting at a later date to review your responses from the interview. If you decide to participate in the second meeting, you will be contacted via

email by the researcher to set up the meeting. The results of your interview will be sent to you prior to this meeting. Your interview responses will not be taken out of the study if you decide not to participate in the second part of this study.

10. What are my responsibilities if I take part in this research?

- Follow the researcher's instructions;
- Tell the researcher right away if you have a complication or injury;
- Answer the questions as honestly and accurately as possible;
- Complete demographic questionnaire, first interview, and second interview if you agree to participate in the second interview.

11. What happens if I do not want to be in this research?

Your participation in this study is voluntary. You may decide not to take part in the research and it will not be held against you. You have the right to: (a) withdraw your participation at any point during this study, (b) refuse to answer any questions, or (c) request the interview be conducted at your pace.

12. What happens if I say yes, but I change my mind later?

If you agree to take part in the research now and stop at any time it will not be held against you.
If you decide to leave the study contact the researcher and your decision to end participation will be documented. If you decide to end participation in the research, information collected during the interview may still be used in the study.

13. Is there any way being in this study could be bad for me?

There is the potential for risk while participating in this study. The risks include potential psychological and emotion discomfort as the topic requires discussion of a traumatic experience. During the course of the interview, you have the right to: (a) request a short break, (b) request that audio- recording be stopped or (c) request a termination of the interview. A request for an end of audio-recording or the interview will result in elimination from the study.

14. Do I have to pay for anything while I am on this study?

There is no cost to you for participating in this study.

15. Will being in this study help me in any way?

We cannot promise any benefits to you or others who take part in this research. However, ***t***his study may have some benefits for participants and mental health providers. Participants might gain a better understanding of physical and sexual intimacy in their relationships. Mental health providers might gain more knowledge of how sexual trauma impacts the intimate relationships of African American childhood sexual abuse (CSA) survivors and how to address intimacy issues with both individuals and couples.

16. What happens to the information we collect?

Your confidentiality will be ensured throughout your participation in the study. All of the information collected from you (demographic survey and consent form) will be kept in a safe and secure location. The materials will be destroyed after a period of three years. The audio-recording of your interview will be sent to a transcriber for the creation of a transcript. Both the audio-recording and transcript will be stored on a password protected USB drive. All of your identifying information will be removed from the transcripts. This information will not appear in any future written documents or presentations. The only individuals who will be given access to your demographic survey, consent form, transcripts and audio-recording are: research team members and the Drexel University Institutional Review Board (IRB) and other representatives of this organization.

17. Can I be removed from the research without my OK?

The person in charge of the research study or the sponsor can remove you from the research study without your approval. Possible reasons for removal include expressing feelings of suicide or homicide.

18. What else do I need to know?

This research study is being done by Drexel University. If you agree to take part in this research study, we will pay you $25.00 in the form of a gift card for your time and effort.

Signature Block for Capable Adult

Your signature documents your permission to take part in this research.

DO NOT SIGN THIS FORM AFTER THIS DATE	→	
Signature of subject		Date
Printed name of subject		
Signature of person obtaining consent		Date
Printed name of person obtaining consent		Form Date

Appendix C Interview Guideline

Interview Guideline

Broad Interview Questions:

-What is your experience of physical and sexual intimacy in your current relationship?
-How (if at all) do you believe an experience of CSA has influenced your experience (s) of physical and sexual intimacy?
-In what way (s) do you believe your current partner's knowledge of your CSA has affected your experience of physical and sexual intimacy?

Detailed Individual Probing Questions:

-How would you describe your experiences of physical and sexual intimacy?
-Tell me about your experiences of physical and sexual intimacy in your current relationship.-Do you feel as though your experience of CSA has impacted how you experience physical and sexual intimacy?

-Do you feel your experiences of intimacy impact your relationship in any way?
-Are you comfortable with how you express physical and sexual intimacy?
-Is one form of intimacy easier for you to experience than the other?
-If applicable, what do you think hinders your expressions of physical and sexual intimacy?
-If you could change anything about how you experience intimacy, what would you change?

Partner Probing Questions:

-How if (in any way) has your partner affected your experiences of physical and sexual intimacy in your relationship?
-From your perspective, how does your partner's knowledge of your CSA affect your experiences of physical and sexual intimacy?
-How does your partner react to the ways in which you express intimacy?
-How would you describe your partner's reactions to how you express intimacy?
-Do you feel your partner is understanding of your experience of CSA?
-Please explain how you feel about the way your partner responds to your expressions of intimacy.

Appendix D Demographic Survey

Demographic Survey

Name:

Race and/or Ethnicity:

Age:

What was your highest completed educational level?

- ☐ High school or equivalent
- ☐ Vocational/technical school
- ☐ Some college
- ☐ College degree (Bachelor's degree)
- ☐ Post college degree (Masters, Doctoral, Professional degree (e.g., MD, JD, etc.)

What is your current household income?

- ☐ Under $10,000
- ☐ $10,000 - $30,000
- ☐ $30,000 - $50,000
- ☐ $50,000 to $70,000
- ☐ Above $70,000
- ☐ I would rather not say

How long have you been in your current relationship?

Race and/or Ethnicity of partner:

Partner's age?

Partner's highest grade level completed?

At what age did you experience childhood sexual abuse?

How many times did you experience childhood sexual abuse?

☐ one occurrence ☐ more than one occurrence

Was your abuser a relative or non-relative? (Please circle one)

Did you have one abuser or more than one abuser? (Please circle one)

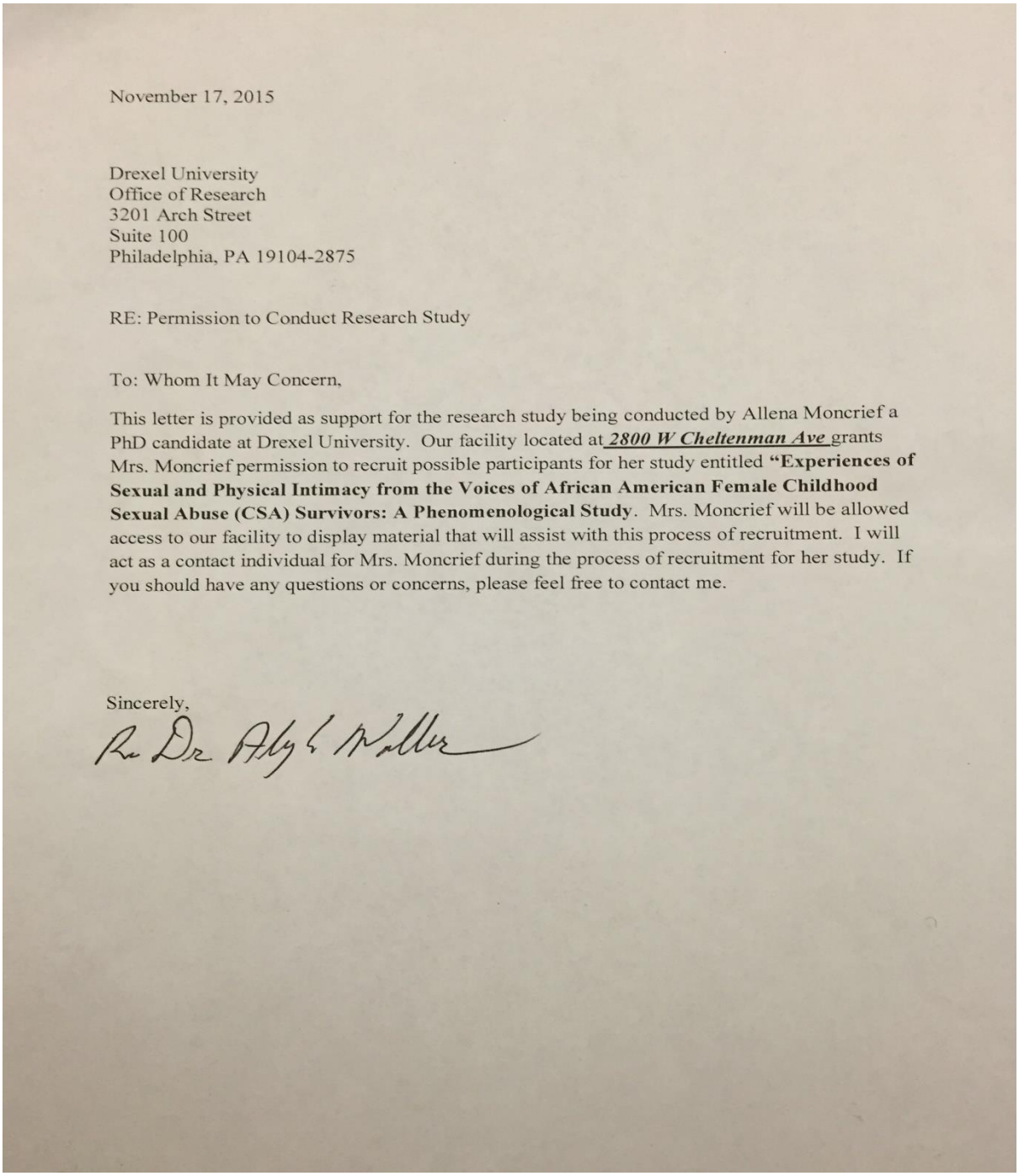
Is your partner aware of your experience of childhood sexual abuse?

Have you ever received treatment for your experience of childhood sexual abuse?

Age treatment was received?

Appendix E Letters of Support from Recruitment Sites

(A) Enon Tabernacle Baptist Church



November 17, 2015

Drexel University
Office of Research
3201 Arch Street
Suite 100
Philadelphia, PA 19104-2875

RE: Permission to Conduct Research Study

To: Whom It May Concern,

This letter is provided as support for the research study being conducted by Allena Moncrief a PhD candidate at Drexel University. Our facility located at ***2800 W Cheltenman Ave*** grants Mrs. Moncrief permission to recruit possible participants for her study entitled **"Experiences of Sexual and Physical Intimacy from the Voices of African American Female Childhood Sexual Abuse (CSA) Survivors: A Phenomenological Study**. Mrs. Moncrief will be allowed access to our facility to display material that will assist with this process of recruitment. I will act as a contact individual for Mrs. Moncrief during the process of recruitment for her study. If you should have any questions or concerns, please feel free to contact me.

Sincerely,

Rev Dr Aly L Waller

(B) Individual, Couple and Family Therapy Clinic

November 13, 2015

Drexel University
Office of Research
3201 Arch Street
Suite 100
Philadelphia, PA 19104-2875

RE: Permission to Conduct Research Study

To: Whom It May Concern,

This letter is provided as support for the research study being conducted by Allena Moncrief a PhD candidate at Drexel University. Our facility located at ***1601 Cherry Street, Parkway Health and Wellness*** grants Mrs. Moncrief permission to recruit possible participants for her study entitled **"Experiences of Sexual and Physical Intimacy from the Voices of African American Female Childhood Sexual Abuse (CSA) Survivors: A Phenomenological Study**. Mrs. Moncrief will be allowed access to our facility to display material that will assist with this process of recruitment. I will act as a contact individual for Mrs. Moncrief during the process of recruitment for her study. If you should have any questions or concerns, please feel free to contact me.

Sincerely,

Erica J. Wilkins, PhD, LMFT

Erica Wilkins, Ph.D.
Clinical Assistant Professor
Couple and Family Therapy
7th Floor, Room 712
1601 Cherry Street, MS 71042
Philadelphia, PA 19102

(C) Therapy Center of Philadelphia

Therapy Center of Philadelphia | AFFORDABLE THERAPY FOR WOMEN & TRANS COMMUNITIES

1315 Walnut Street, STE 1004
Philadelphia PA 19107
T 215.567.1111
therapycenterofphila.org

November 18, 2015

Drexel University
Office of Research
3201 Arch Street
Suite 100
Philadelphia, PA 19104-2875

RE: Permission to Conduct Research Study

To: Whom It May Concern,
This letter is provided as support for the research study being conducted by Allena Moncrief, a PhD candidate at Drexel University. Our facility ***Therapy Center of Philadelphia*** grants Mrs. Moncrief permission to recruit possible participants for her study entitled **"Experiences of Sexual and Physical Intimacy from the Voices of African American Female Childhood Sexual Abuse (CSA) Survivors: A Phenomenological Study**. Mrs. Moncrief will be allowed access to our facility to display material that will assist with this process of recruitment. I will act as a contact individual for Mrs. Moncrief during the process of recruitment for her study. If you should have any questions or concerns, please feel free to contact me.

Sincerely,

Mona Cardell, Ph.D.
Clinical Director
Therapy Center of Philadelphia
1315 Walnut St., #1004
Philadelphia, PA 19107

WHOLENESS. TRANSFORMATION. CONNECTION.

Appendix F Therapeutic Locations

Sexual Trauma and Psychopathology Program
Center for Cognitive Therapy
University of Pennsylvania
3535 Market Street, 2nd Floor
Philadelphia, PA 19104
215-898-4106

The Center for Growth
233 S. 6th Street
Suite C-33
Philadelphia PA, 19106
267-324-9564

Women Against Abuse: Advocacy in Action
100 South Broad Street, Suite 1341.
Philadelphia, PA 19110
215-985-3315

Women's Trauma Empowerment And Recovery Group
Ms Yaritza Zayas
Philadelphia, PA 19135
856-282-2679

Incest and Sexual Abuse Survivors Meetup Support Group
Philadelphia, PA
http://www.meetup.com/Incest-Survivors-Anonymous/

Family Therapy Treatment Program
1200 Callowhill Street
Suite 104
Philadelphia, PA
215-413-0141

Appendix G Formulated Meanings, Theme Clusters and Emergent Themes

Segment (Actual Phrase)	Formulated Meaning	Theme	Emergent Theme
I will say that I also, I also kind of, I also, I kind of gravitate like, seems like towards older men, but, and that may have something to do with the abuse.	Gravitation toward intimate relationships with older men; belief that this could be connected to CSA	Sexual preference: older men & promiscuity	Fragmented early sexual experiences and intimacy following CSA
I feel like, maybe, it may have caused me to be, um, maybe a little promiscuous earlier on.	Experience of abuse identified as the possible contributing factor to promiscuous behavior	Sexual preference: older men & promiscuity	Fragmented early sexual experiences and intimacy following CSA
Well, I started having sex at an early age. I wanna say, probably like around thirteen. I didn't have sex with like a lot of people, or multiple people, it was just like, I had started having sex at a young age.	Early engagement in sex after experiencing CSA	Sexual preference: older men & promiscuity	Fragmented early sexual experiences and intimacy following CSA
It affected me before him before I let older men touch me because I felt like they liked me or they accepted me or they loved me or something like that because they put their hands on me or they touched me in this way, so I felt loved. So that's how it affected me like with teenage relationships. I mean I was 16 dealing with a 29-year-old man.	A yearning to feel loved and accepted led to inappropriate touch and sexual interactions with older men	Sexual preference: older men & promiscuity	Fragmented early sexual experiences and intimacy following CSA

I just wanted sex because I wanted to feel loved. People I don't remember their names, I couldn't tell you, older men. I was a bartender at a bar and I wasn't that bad.. at that time I don't think I was, but tell me what I wanted to hear and you may have an opportunity. I had several one night stands and I think back to them (what I do remember about them) because half the time I can't even remember the men	Engagement in promiscuous behavior (with older men) just to feel loved	Sexual preference: older men & promiscuity	Fragmented early sexual experiences and intimacy following CSA
I can think back to so many situations where I was used just for sex.	Lack of respect for body stemming from being used by men for sex	Sexual preference: older men & promiscuity	Fragmented early sexual experiences and intimacy following CSA
I would see men and I would just go for it. It was the attention from men which was very, very controlling for me. It was like, "I got to have that. I need to know that you like me, I need to know that I'm attractive."	Engagement in promiscuous behavior for the purposes of being liked and feeling attractive	Sexual preference: older men & promiscuity	Fragmented early sexual experiences and intimacy following CSA
Just one of those looking for love in all the wrong places type of things. Feeling like if I had sex with someone or something like that than they would love me or like me.	Engagement in promiscuous behavior for the purposes of feeling loved or liked by men	Sexual preference: older men & promiscuity	Fragmented early sexual experiences and intimacy following CSA
I had to remember that I have a right to say no.	Beliefs that engagement in sex	Sexual preference: older	Sexual preference: older

I have a right to say whether I want to or not. For a long time I remember with a man, unless you made love to me I didn't think you loved me.	with a man was the only way to know that they loved you	men & promiscuity	men & promiscuity
I defined love for a lot of years through sex.	Defining of love in intimate relationships through sex	Sexual preference: older men & promiscuity	Sexual preference: older men & promiscuity
I think I used to have sex just to feel loved and wanted. I kept doing it to myself.	Engagement in sex with men to feel loved and wanted	Sexual preference: older men & promiscuity	Sexual preference: older men & promiscuity
I've blocked out a lot of my sexual experiences between18 - 26. I was just having it to get it over with and I had to stop that too. I just found myself lying there one time like, "What am I doing? I really don't want this."	Engagement in sex without a purpose; no mental/deep connection to the individual, just waiting for it to end; as a result, mental blocking of sexual experiences	Sexual preference: older men & promiscuity	Sexual preference: older men & promiscuity
And that's what I think it was, I just jumped right in there and it was just sex and that's it. Like I'm just here.	No significant feelings about the sex that was occurring with the other individual; engagement in sex without any feelings or emotional connection with the other individual	Sexual preference: older men & promiscuity	Sexual preference: older men & promiscuity
Yeah. There really wasn't any intimacy just sex. It was just like, "You done?"	No intimate connection to the sexual partner; during the process of having sex just waiting for it to end	Sexual preference: older men & promiscuity	Sexual preference: older men & promiscuity
It was hard for me to understand like – okay, a lot of times you're not really educated on what sex is so you're	Engagement in sex without involvement of feelings due to low self-esteem	Sexual preference: older men & promiscuity	Sexual preference: older men & promiscuity

just having sex because everybody is doing it. But for me, it was like I was having sex but I never let my feelings get involved. So, if I was to have intercourse with somebody it would be nothing because, number one, I had low self-esteem so I was like, "Oh they never going to call me back or whatever." It was just like, "If he calls cool, if he don't he don't." But I think that was a part of me being insecure and me having low self-esteem thinking I'm not good enough for somebody so I would just do it just to do it and not really be attached. Like no feelings, no nothing, I would just be there.			
I'm turned off, you know like a way if you touch me in a way that I necessary don't like	Physical touch is difficult to experience in intimate relationships after enduring abuse that consisted of physical touch	Avoidance of intimacy similar in nature to CSA Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
I guess what happened to me more frequently, was you know, is the sexual part. So, yeah I think that's why I'm less, receptive in that area …. I guess it was, I guess experiencing growing up, a lot of flashbacks, so, um, and I just always, thought,	Because penetration and other sexual interactions were most endured during CSA, sexual intimacy is the form of intimacy survivor is less receptive to experiencing; there is connection between the form of abuse most	Avoidance of intimacy similar in nature to CSA	Fragmented early sexual experiences and intimacy following CSA

it always just felt like it was being repeated	endured and form of intimacy most difficult to experience		
In the past, I couldn't deal with being touched in like an intimate way. Every time it would start I would break down.	Touch was difficult to experience in the past; experiences of touch would lead to emotional break downs	Avoidance of intimacy similar in nature to CSA	Fragmented early sexual experiences and intimacy following CSA
After the abuse everybody was just cut off with hugs and I didn't hug nobody.	After experience of CSA that involved physical touch, elimination of the actions that were similar to the endured abuse; an unwillingness to engage in physical touch with any one	Avoidance of intimacy similar in nature to CSA	Fragmented early sexual experiences and intimacy following CSA
I didn't want no physical contact. We could speak, but I wouldn't even be in the room with a male figure, not by myself.	Elimination of physical contact with others after enduring CSA that involved physical touch; difficulty with closeness to individuals that were of the same sex as the abuser	Avoidance of intimacy similar in nature to CSA	Fragmented early sexual experiences and intimacy following CSA
In the beginning it was hard and I thought the relationship wasn't going to last because I thought he was going to get sick of me not wanting to be hugged and kissed and touched	Identification of physical intimacy as more difficult to experience	Avoidance of intimacy similar in nature to CSA	Fragmented early sexual experiences and intimacy following CSA
Yes it did, because I actually used to be married. My ex-husband and I are now friends and we discussed the past. I explained to him some of the moments where I	Experience of abuse led to an inability to open up sexually in intimate relationships	Avoidance of intimacy similar in nature to CSA	Fragmented early sexual experiences and intimacy following CSA

just couldn't bear to be intimate with him and we actually went over why. It was very healing to revisit that past relationship because that was one that I really took to heart and when things didn't work out, I would say that was the start of the process of me trying to figure out what is going on with me that I can't really open up to somebody that I love or that I can push this person away. So yeah, it has impacted how I interact with someone sexually.			
there are times when, "Don't even touch me." It's different now, of course, because now I just welcome love and I welcome the expression of love. I wouldn't say that I'm 1,000% there, but I will say 999%.	An avoidance of physical intimacy after CSA that involved unwanted touch, but acknowledgement that things are shifting in a positive direction within the current relationship	Avoidance of intimacy similar in nature to CSA Process of learning to experience positive intimacy after abuse	Fragmented early sexual experiences and intimacy following CSA
I used to hate being touched, but see I grew out of it. Because when I was young, it was my cousin but the way he used to hug me I didn't like it. When I got older, I am not want nobody to hug me because the way he hugged me I didn't like it so I didn't want everybody else to try to do that too, so I would just push that all off	After the abuse, there was a lack of acceptance/engagement in physical touch as a way of avoiding the type of abuse that was endured in childhood; intimate relationships were avoided to prevent enduring acts that were similar to the abuse; survivor did not voice discomfort with the acts at that time instead just avoided	Avoidance of intimacy similar in nature to CSA	Fragmented early sexual experiences and intimacy following CSA

from everybody. I didn't want no hugs from nobody.	them and pushed people away		
The first relationship was 16, but that only lasted like six months and then I left it alone because I couldn't take being hugged by him.	Inability to maintain longevity of a relationship due to struggles with receiving physical intimacy	Avoidance of intimacy similar in nature to CSA	Fragmented early sexual experiences and intimacy following CSA
I didn't like massages, I didn't like hugs, didn't like to be touched, but the sexual part, that was the only thing that I was able to do, but there was, I wasn't still 100% comfortable with that.	An avoidance of any form of touch due to discomfort; behaviors being avoided are similar to those experienced during CSA	Avoidance of intimacy similar in nature to CSA	
Yes, uh-hmm. I'm comfortable with how I express both forms of intimacy.	Level of comfort with both physical and sexual intimacy after CSA	Comfort with intimacy/no negative impact after CSA	Fragmented early sexual experiences and intimacy following CSA
Personally, I don't feel is has impacted my experiences. I don't reflect back or have any ill feelings. When I'm being touched I don't think back to the past or anything like that, so I would say no	Beliefs that past experience of abuse has no bearing on intimacy in relationships	Comfort with intimacy/no negative impact after CSA	Fragmented early sexual experiences and intimacy following CSA
Yeah. Putting it like that it makes sense. Any type of touch that feels like what I went through when I was younger is hard for me to experience	Physical touch that feels like the type of abuse endured is difficult to experience	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
I think the sexual intimacy, once we get into the move it's easier. Like I said, it takes a while just getting through the touching and all that. It	Identification of sexual intimacy as the easier form of intimacy to experience; struggles with getting through physical intimacy	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA

takes me a minute to get comfortable, but as far as the sexual intimacy, it's not as bad. It's easier to manage than the physical.	(which is more difficult to experience) to sexual intimacy		
Yes; I prefer the whole nine yards. I like sexual intimacy over physical intimacy.	Acceptance of sexual intimacy over physical; a preference for the type of intimacy that is opposite of the abuse that was endured during childhood	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
Yes; both forms of intimacy made me uncomfortable. However, physical intimacy has always been more difficult for me.	Acknowledgement of how intimate experiences similar in nature to the abuse were difficult	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
I wasn't always comfortable, with that, I guess, before, just before coming out, like to my family about the sexual abuse and everything and um, I don't know, I just wasn't always comfortable with intimacy... physical intimacy and sexual intimacy.	Lack of comfort with expressions of physical or sexual intimacy prior to opening up about abuse	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
I wasn't always comfortable, certainly not always, it was always a state of fear...during...a lot of fear, during sexual intimacy, and I did not partake in, um, physical intimacy.	Before marriage there was a great deal of fear during experiences of sexual intimacy in relationships; dislike of almost all interactions that involved touch in an intimate relationship; discomfort with sexual	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA

	intimacy, but it was easier to experience than physical intimacy		
I was uncomfortable because..., I guess it was, I guess experiencing growing up, a lot of flashbacks, so, um, and I just always, thought, it always just felt like it was being repeated.	Experiences of intimacy were uncomfortable because it felt like the abuse was being repeated	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
I've learned that it's a journey, and that undergoing years of sexual abuse, um by people, that I trusted, and I don't expect it for me to be like 100% OK in the area of sexual intimacy.	Expectation that there will never be 100% comfort with the intimate experiences that are similar in nature to the endured abuse	Discomfort/fear of intimacy Process of learning to experience positive intimacy after abuse	Fragmented early sexual experiences and intimacy following CSA
I think over the years I'm getting better with it. It's certain things that I'm uncomfortable with, that I think I've always been uncomfortable with since I was younger. Currently I'm getting better. I had an issue where I didn't like to be hugged. I'm not one for kissing in public and sex used to be uncomfortable, but I think I'm getting better with it.	Feelings of discomfort with physical touch (kisses, hugs) after the abuse; acknowledgment that physical intimacy is getting better with others as time progresses	Discomfort/fear of intimacy Process of learning to experience positive intimacy after abuse	Fragmented early sexual experiences and intimacy following CSA
I'm 29 now. I didn't have sex until I was 18 and then even after that, it was here nor there because I was never comfortable with exposing myself to other people or guys	Feelings of discomfort with physical and sexual experiences; a lack of full engagement in both forms due to level of discomfort after abuse; in comparison to other	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA

touching me. I was never fully involved in it and it was always uncomfortable.	females, late on-set of engagement in sexual behavior		
Just touching period was hard for me. If a guy would try to rub my arm or – I think when you're young it starts with guys wanting to hug you and stuff but I was always leery about the hugging turning into other things. Even when I got closer with other men, the touching made me nervous because I was always wondering what it was going to lead to. Then even when I was ready to have sex, I just would tense up.	Survivor identifies touch as hard to experience; description of discomfort and suspension of hugs especially from men; nervousness about the potential of hugs turning into sexual activity even in the context of intimate relationships; during sexual experiences inability to relax and fully enjoy the act.	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
Yes, I do think my experience of abuse has had a huge impact. I honestly think that's part of why my other two relationships didn't last. The first one didn't last too long, maybe a year. Then the second it was pushing around the same time as this one, but I think that it didn't last because I felt like I couldn't get past it. I don't know what's different between the last one and this one. I think the acceptance was probably different	Belief that abuse has had a huge impact on intimate relationships; inability to maintain intimate partnerships for long periods of time due to experience of abuse and discomfort with intimate experiences; partners' acceptance of discomfort and struggles with intimacy play a part in longevity of relationship.	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA

Yes; both forms of intimacy made me uncomfortable. However, physical intimacy has always been more difficult for me.	Identification of both forms of intimacy as uncomfortable.	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
it's hard for me to be attached to somebody like that, something physical that would kind of attach you to somebody because that's not what I wanted, you know what I'm saying?	Due to experience of abuse, difficulty engaging in physical touch because of the fear of developing an attachment with the individual	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
as an adult even when I was in other relationships, hugging, kissing, all of those things was kind of like, if I feel those it felt it was something wrong with it. If I did those things I just felt bad about doing it, about getting close to people. So a lot of times in my previous relationships, I used to think it was something wrong. And plus I had detachment issues anyway as far as physical, like I wouldn't kiss certain guys, you know; I wouldn't touch certain guys so it was like kind of something that I just didn't know about.	Survivor had issues with physical intimacy in the past due to abuse; belief that there was something wrong with engaging in acts such as hugging and kissing	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
Like I don't mind having sex, but like I say, it's the emotional part that opens me up. And maybe because I	Engagement in sex without having an emotional connection to the sexual partner; difficulty with	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA

still have my guard up as far as getting close to people or getting close to men because of what I've been through, so I think that may be part of it, because I'm like oh I shouldn't fall too fast or everything is just always so tense or so rush-rush, how everybody else thinks it should be.	building an emotional connection with sexual partners due to fear of getting close to men; fear results from past experience of abuse		
I pretty much hold back a lot and I don't believe what the person is saying so it's like you've got to prove it to me. So it still holds me back from just kind of letting go and being comfortable with what I'm doing instead of worrying	Inability to trust causes survivor to hold back in relationships and prevents comfort with partner	Discomfort/fear of intimacy	Fragmented early sexual experiences and intimacy following CSA
I defined love for a lot of years through sex. I was married before my new partner. I remember times when he didn't say anything. He wouldn't talk. He would hold you if he felt like it. I used to think, "Well that means you're not attracted to me, I'm not beautiful in your eyes, you don't care for me, and you don't love me." My ex-husband told me, "It's not that, I will always love you. You're always #1 in my heart. I want you to start to understand that if a person doesn't	Negative view of self if physical and sexual intimacy was not present in relationship; inability to understand that physical and sexual acts do not have to occur in order for love to be present in a relationship	Adversity caused by CSA	Fragmented early sexual experiences and intimacy following CSA

touch you or doesn't make you feel sexually satisfied it does not mean they don't love you, it doesn't not mean you're special to them, they just might not be feeling like that at the time.			
Sometimes I've done it without the feeling. I didn't feel bad or anything I just faked it, you know. But then I kind of wished I didn't?	A lack of mental connection to the intimacy that is occurring; enjoyment of the act is faked	Adversity caused by CSA	Fragmented early sexual experiences and intimacy following CSA
the fact that the last relationship he took it personal, by me never being comfortable with him and eventually I found out he was cheating and I took that personal because I wasn't' performing and I was hesitant to do certain things	Feeling that relationship ended due to partner's inability to accept discomfort with intimacy; survivor felt personally responsible for the termination of the relationship due to inability to engage in certain intimate acts	Adversity caused by CSA	Fragmented early sexual experiences and intimacy following CSA
It happened when I was 10, I'm 29 now and the last relationship that knew the most about it, his thing was "Well it happened so long ago and you had other relationships, you had sex, so why is it still bothering you?" I think he took it more personal like, "Oh you just don't want me touching you," when that wasn't the case.	Partner did not understand the connection between abuse and difficulty with intimacy; belief that partner took struggles personal instead of being understanding	Adversity caused by CSA	Fragmented early sexual experiences and intimacy following CSA
I'm cool, but two days later I'm crying, I'm like he don't want me, he not going to call me	Survivor became emotionally distraught after some intimate experiences; there	Adversity caused by CSA	Fragmented early sexual experiences and

no more; just things like that. So I go on this emotional roller coaster afterwards. Even if they don't give me that sign, it's just always in the back of my head.	were no issues during the act, but survivor became consumed concerns of being accepted by male companion		intimacy following CSA
It's like, okay, I'll have sex but I'm not going to do this, but then I still ended up doing it and then I feel bad about doing it. You understand what I'm saying?	An inability to maintain boundaries around sexual experiences with partners	Adversity caused by CSA	Fragmented early sexual experiences and intimacy following CSA
ever since I kind of did some soul searching I'm understanding that even though sex is a good thing, emotionally it's not really good for me because it just opens some stuff emotionally, so it's kind of hard. It's not even during the act, it's usually after the act. I get very emotional and just kind of feel like I'm giving myself and I need from this person, I need more time. It's like I get more needy	After sex client experiences emotional turmoil resulting from belief that her body is freely being given away and connection of some sort needs to be maintained with the person	Adversity caused by CSA	Fragmented early sexual experiences and intimacy following CSA
I need to learn how to just slow down, chill out, relax, take your time because everything is, "Oh I gotta be in a relationship, oh I've got to do this, I got to do that," and not really getting into that person. So, I'm kind of trying	Tendency to jump into relationships with men without actually getting to know them first resulting in failed relationships that end up being just about sex which survivor doesn't like	Adversity caused by CSA	Fragmented early sexual experiences and intimacy following CSA

to break that cycle as well and not make the relationship just about sex most of the because that's what it almost always end up being			
I remember having a flashback washing dishes. My boyfriend just came to give me a kiss. Every time he brush his teeth and comes and gives me a kiss and that's the first time he ever caught me off guard. I was washing dishes and he pulled my ponytail. Now, this part is very sensitive. I blanked out. I turned and smacked him and we tussled.	Unexpected touch (even though harm is not intended) triggers a fight and flight response	Adversity caused by CSA	Fragmented early sexual experiences and intimacy following CSA
He's not always a really understanding person, um, but as far as like um, the physical, sexual intimacy, he's understanding about that, so maybe him knowing that maybe it does make him be more understanding, to that.	Survivor describes how partner is not an understanding person in general, but he is understanding when it comes to physical and sexual interactions in their relationship	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
it may have, affected it, more in a positive way, because I feel like it made him, it makes him be more understanding.	After disclosure of abuse to partner, he became more understanding of expressions of intimacy	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy

I was always very open and honest with him about you know, what occurred. And he, um, you know, so he knows, and he understands.	Survivor explains how being open and honest about her experience of abuse to her partner helped him understand the ways in which her past of CSA impacts intimate experiences	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
He definitely understands. In the beginning he didn't understand, but he understands now. A couple of years ago he used to get upset. So that's how that affects me as far as that's concerned.	Partner currently understands survivor's history of CSA; in the past he struggled to understand survivor's difficulty with engaging in sexual intimacy	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
After I told him about the abuse, we started learning each other's boundaries and that's when the boundary talk came in. That's where it was if I don't feel like doing this, you shouldn't force me to do this. If you don't want a kiss I shouldn't force you to want a kiss. If I don't feel like being touched, I don't feel like being touched.	There were issues with physical and sexual intimacy in the relationship prior to disclosure; after partner learned about the abuse things with intimacy changed; survivor and partner discussed importance of boundaries in relationship and importance of not forcing intimacy	Understanding of impact/patience Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
he's understanding...I do know he's understanding of my past.	Partner is understanding of partner's past	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
I think with him knowing, it provides the opportunity for him to be understanding so when I flinch, he knows why I'm doing it and he's not taking it	Partner's knowledge of abuse has assisted him with gaining an understanding of why survivor may display negative reactions to	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy

personal or taking it as, "Oh she's uninterested."	intimacy (esp. physical) at times		
Yes, I do feel that he's understanding of my past	Partner understands how past experience of CSA impacts expressions/receptiveness of intimacy	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
Just of the situation of what I went through. Just not really pressuring any issue or anything like that or making me feel bad. Just being understanding	Survivor feels as though partner does not put pressure on her to engage in intimate moments; he understands the times when survivor does not want to engage in intimacy	Understanding of impact/patience Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
Like if I'm not in the mood or I'm not being very intimate or physical at that time he is understanding of it.	Partner understands times when survivor does not want to engage in physical or sexual intimacy	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
I guess because I don't feel like it's had an effect on our physical or our sexual relationship, so I feel like with that being said, he's pretty understanding because it's never really been an issue. I mean in the same breath, I guess because it's never really been an issue, it hasn't really caused a conversation for me to know if he feels as though my past impacts anything, you know.	Survivor believes abuse has never been an issue in her relationship; considering abuse has never impacted/hindered intimacy, she is unsure if his knowledge has played a role in their intimate experiences	Uncertainty about impact of knowledge	Partner's awareness has helped create positive experiences of intimacy

If there were any times when things were a little awkward, it may have been easier for him to support me knowing the information. I feel like it was more of a when or how it makes me feel. So I feel like since knowing he was supportive. I don't feel like he shunned me away or anything, treated me any differently, or anything like that	Partner is described as supportive; even during the times when survivor has felt awkward in their intimate moments, partner has never reacted negatively or treated survivor in a manner that's outside of the norm	Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
he does not force me, which helps me. And what he will do things like hug me. Like I have to have physical touch first	Partner does not force intimacy; he allows survivor to chart the course in their intimacy; before sexual intimacy partner will always engage in touch (physical intimacy) which helps put survivor at ease before sex	Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
before we even got to intimacy, we used to make sure are you even in the mood? Are you even there, because if you're not there it's no point in doing it? It was one time when he was ready and I was like, "Oh no, I'm just not. Please don't feel bad, please don't get mad, I'm just not there right now." He was like, "No baby, it's okay,"	There is a lot of negotiating surrounding intimacy; before engaging in sexual intimacy partners have a discussion about comfort with engaging in intimacy at the moment.	Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy

I don't think he wants to force sex on nobody or make it seem like it's not wanted. Some men are very cautious about that. I think that's pretty much what it is. He's sensitive about that and he's like, "I'm not going to rape you. If you're not comfortable we can stop."	Partner is cautious about engaging in intimacy with survivor; he does not force sexual intimacy and displays a level of sensitivity when survivor experiences discomfort	Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
He just pretty much, you know. He's not that type of person – he's like, "Well you want me to stop," and he'll give me that option. That's a good thing because some people just don't care but he's like, "Do you want me to just stop," or "Can I do this," or "Is it okay for me to do this?" I think he gets it in that sense, as well. I think that's a good thing for me,	Partner has awareness of possible ways intimate moments can lead to triggers; he constantly checks in with survivor during intimate moments and makes sure survivor is comfortable with what is taking place	Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
I feel good and confident. I feel embraced and accepted as I am. I feel we complement each other, so I feel what I offer him he embraces it and it kind of makes me feel like I'm great where I'm at. Confident, that's the best word I can use. It makes me feel confident.	Partner embraces and accepts survivor's struggles with intimacy; he assists her with gaining confidence in her expressions of sexual and physical intimacy	Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy

Kind, nurturing, he makes sure that I feel good about myself. I mean I do feel good about myself but he just adds to that and I'm just grateful, so that's the best thing I can say where that's concerned.	Partner is kind and nurturing which has assisted survivor with feeling confident and good about herself which leads to improved intimacy	Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
I feel like he does everything he can to make sure that I'm aware of today and not think about yesterday, because yesterday is not here anymore. By him knowing what I had gone through, maybe he is more affectionate, I don't know. The way he is with me is the way he is. He's very nurturing.	Partner makes sure survivor is aware of the present to avoid reflections on the past; his knowledge of the abuse has led to more affection and nurturing	Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
He's very receptive. He appreciates and enjoys my personality where sexual is concerned or where physical intimacy is concerned.	Partner is receptive to possible hinders to intimacy; he appreciates the effort that survivor puts forward when it comes to sexual and physical intimacy in the relationship	Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
he was able to be patient with me, and understanding	Partner is understanding of intimate expressions and displays patience with any issues that may arise	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
I would say he's more patient. He's not, um, he's definitely more, he's definitely understanding, um, and just aware. He's very aware, he makes sure	Survivor describes how partner is patient during their intimate moments and aware of actions that might trigger a negative response; he is also	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy

that, like, to ask me, am I ok or is there anything that makes me uncomfortable? So he's very aware.	understanding given that there are times when intimacy is not desired by survivor		
He is very patient. Very understanding. Um, not a push a over. Makes it feel very safe.	Partner described as patient and understanding; he makes survivor feel safe during their intimate moments.	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
He has patience with me. That's how he has affected our experiences of intimacy because he's very patient with me.	Partner described as patient which assists with how survivor experiences sexual intimacy in their relationship	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
It took me a while to tell him but he knows everything and he always seems concerned and that I have a right to still feel unsafe. He works with me, he's patient with me, and he doesn't take offense.	It took survivor a while to tell partner about the abuse; after learning about the abuse partner validated survivor's feelings of feeling unsafe during intimate moments; partner described as patient with intimate difficulties and he doesn't take offense whenever survivor does not want to engage in intimacy	Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
He is a very affectionate person and I do struggle with it but he's patient with me and he doesn't take offense when I recoil or he doesn't get upset when I'm slow to react to his intimacy.	Partners differ in their levels of affection; partner is a very affection individual but survivor struggles with showing affection; partner doesn't get upset, react negatively or take offense	Understanding of impact/patience Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
He's patience, his understanding. I think the validation, like he	Partner described as patient and understanding; he	Understanding of impact/patience	Partner's awareness has helped create

makes me feel like it's okay to still have some effects from it	validates survivor's struggle with intimacy and acknowledges how an experience of CSA can still have a negative impact in the present	Creation of comforting environment	positive experiences of intimacy
He may not get it at the time that there's something that could possibly happen and I stop him or I react in a certain way; he may not get it at the time, but once he thinks about it and/or we'll talk about then it puts it into perspective for him and he does understand where it stems from. But he does know that practically everything, when it comes to sex, it relates back to my past.	Survivor explains how partner may not realize that something has triggered a flashback to the abuse in the moment, but after giving it some thought and discussing the matter, he understands	Awareness of triggers that negatively affect intimacy Understanding of impact/patience	Partner's awareness has helped create positive experiences of intimacy
He knows that pretty much everything– like if I tell him, "No," or if there's something that comes up he relates it back to that. He'll ask me, "Was it because of this," or "What happened that you don't…?" We have an open dialogue and we try not to hold back anything. He knows certain things will trigger a reaction out of me.	Partner has an awareness of the things that trigger flashbacks to abuse during sexual intimacy and he has open dialogue with survivor about triggers	Awareness of triggers that negatively affect intimacy Creation of comforting environment	Partner's awareness has helped create positive experiences of intimacy
He's learned to may attention. He has learned to point out these different things that could possibly	Partner has learned how to pay attention to the different things could lead to trigger	Awareness of triggers that negatively affect intimacy	Partner's awareness has helped create positive

trigger me or possibly upset me. He knows how to respond to it and how to care for it. Like if he knows I'm up in the middle of the night and he knows I can't sleep or I shake my leg which I do when I can't sleep, things like that. He'll get up and turn on the light and say, "Let's talk about it. What is it? What happened? What are you thinking about?"	(s) or cause survivor to become upset	Creation of comforting environment	experiences of intimacy
We had physical and sexual intimacy prior to me telling him about the intimacy, I don't feel like me telling him about the intimacy changed anything about the intimacy between us.	Partner has knowledge about the abuse, but survivor doesn't feel as though it has had an impact on their intimate experiences	No impact	Partner's awareness has helped create positive experiences of intimacy
In the past I feel like my abuse has impacted intimacy in my relationships, but I don't think about it no more. So, I don't think it has an impact now.	Beliefs that abuse has had an impact on intimate experiences that occurred prior to current intimate relationship, but it has no impact in the present	No impact	Partner's awareness has helped create positive experiences of intimacy
He wasn't too pleased. He said he wanted to hurt the person and I was like, "Just don't worry about it because they gon' be dealt with sooner or later," and ever since then he left it alone. But it has never impacted our intimacy	Partner expressed anger about survivor's experience of abuse; survivor doesn't feel as though experience of abuse has impacted intimacy experiences in any way	No impact	Partner's awareness has helped create positive experiences of intimacy

we're very intimate with each other. We have sex on a regular basis, we're both very engaged in it. Um, we're really like, both, into each other. So, it's probably more than good.	Description of intimate relationship as good; sex between partners occurs on a regular basis and both partners are equally engaged in it	Positive Experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
We both focus on pleasing each other, so I would say that it's pretty good	Description of intimate relationship as good; Both partners focus on pleasing each other	Positive Experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
yea, I'm pretty comfortable, with our intimacy. I'm really, I'm a really open person, I really have no issues, like saying what I like, or what I don't like, um, so, yeah. I'm, um, pretty open with everything,	Survivor is comfortable with the level of intimacy displayed in the relationship; a contributing factor to survivor's level of comfort is description of self as open and willing to identify what's enjoyable and what's not	Positive Experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
my husband and I, we're very…we're very intimate. I think any challenges we may face, are probably more, just that comes with time, being together for so ,long. and Normal stuff that people experience, after they've been together for a while. But we have a good physical and intimate relationship.	Physical and sexual intimacy is described as good; belief that issues that arise in relationship are not outside of the norm	Positive Experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

Yes, I'm comfortable touching, kissing, hugging, lovemaking, and sex, of course.	Individual expresses comfort with physical and sexual intimacy in current partnership	Positive Experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
My current relationship is pretty much very intimate both sexual and physical.	Physical and sexual intimacy is a regular part of survivor's partnership	Positive experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I feel like we both are on the same accord when it comes to our physical and sexual relationship. I don't think he has an affect like if he wants it more than me or if I want it more than him I feel like we kind of intertwine and we're on the same level when it comes to that.	Both partners are on the same accord when it comes to the physical and sexual intimacy in the relationship; they both enjoy the intimacy and equally want it to occur	Positive experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
positive, especially with the physical, physical intimacy part. I'm more receptive to it. um, I'm, I feel safe.	Intimate experiences in partnership are described as positive; survivor is more receptive to physical intimacy because it feels safe	Positive experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
The experiences of both physical and sexual intimacy feel good to me in my marriage.	Physical and sexual intimacy feels good within the context of partnership	Positive Experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

I'm fine with just cuddling. Like showing me that form of intimacy. You have your needs and I have my needs. My needs are more in the present...hold me, rub my hair…without it turning sexual.	Survivor identifies physical intimacy as the most comfortable to experience as desires for sexual intimacy are not always present	Positive experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
He's 45 and I like men in that age range. A person in my age range can't do the things that he can do for me and the intimacy. He satisfies my physical and sexual needs.	There is a preference for men in an older age group as individuals in similar group cannot satisfy sexual needs; acknowledgement that partner (who is older) satisfies both sexual and physical needs	Positive Experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
Just the kissing, the hugging, the rubbing and everything. Everything he does help make intimacy better for me.	Survivor expresses comfort with the physical and sexual that is experienced in the relationship; partner is credited with helping survivor feel level of comfort during intimate moments	Positive Experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I'm comfortable with our intimate experiences. I think I just jumped in them relationships so I could be in a relationship. I just jumped right into it. I didn't even get a chance to know the person, I didn't get a chance to fill you out or nothing. Now this one I've known him 13 years. I know him in and out, left and right, up and down	Survivor explains how building a solid foundation with partner (which is different from past experiences with partners) has helped with creating a level of comfort with physical and sexual intimacy	Positive Experiences of intimacy Process of learning to experience positive intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

I can experience physical intimacy in this relationship, but not the others. See, I feel safe with him.	Survivor explains how she can experience physical intimacy in this relationship without any difficulty due to feelings of safe; in past relationships survivor was unable to engage in physical intimacy because it felt unsafe	Positive Experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I'm comfortable with the intimacy. It's crazy because it feels like it was meant to be. Every time we have sex it feels like it was meant to be	Expression of comfort with sexual intimacy in current partnership; belief that comfort with intimacy is an indicator that the relationship is meant to be	Positive Experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
It is a lot different. We hug a lot, we touch each other a lot, it's more intimacy than I ever really had in my previous relationships. So it's different.	Survivor explains how current relationship has more physical intimacy than all other previous relationships	Positive experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
We are still attracted to each other. We still turn each other on. We still enjoy being intimate with each other. So I feel like that makes it very good especially after 20 years I feel like the intimacy is more like great.	Intimacy and attraction are described as strong in relationship; given the longevity of the relationship, survivor feels these things are still intact	Positive experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I'm very comfortable with the intimacy in my marriage. The comfort level is a 10; 10 being good.	Survivor describes a level of comfort with intimacy in marriage	Positive experiences of intimacy	"Healthy/ Positive experiences of intimacy; residual effects of

			abuse present”
I would say that physical intimacy is easier to experience, and I think the reason that is, um, again, it's a form of safety for me, um a form of reassurance,	Physical intimacy identified as the easiest form to experience. Survivor explains how feelings of safety and reassurance that grow out physical intimacy causes it to be easier to experience than sexual intimacy	Positive experiences of intimacy	“Healthy/ Positive experiences of intimacy; residual effects of abuse present”
I get turned off, very easily. But I don't know if it's just me, or women in general. You know, we're mental, they're visual. So, it's like the smallest little thing could like, turn me off. And sometimes I feel like that might be an issue.	Intimacy does occur, but individual gets easily turned off; Uncertain if this is connected to abuse or struggles of being a woman	Triggers and challenges that negatively impact intimate occurrences	“Healthy/ Positive experiences of intimacy; residual effects of abuse present”
After a while physical for me gets very – I get annoyed very fast. I have a tendency to get very irritated sometimes real quickly. It’s of no fault of the person, it’s of no fault of our surroundings, it’s just sometimes we can be close and it’s like I need a break.	Physical intimacy can feel irritating after belief that it has occurred for a prolonged amount time; a break is needed from the physical intimacy once irritation occurs	Triggers and challenges that negatively impact intimate occurrences	“Healthy/ Positive experiences of intimacy; residual effects of abuse present”
Like I enjoy it but I'm timed after 5 minutes I'm like when are we done? I wish it could enjoy it a little bit more and that all goes back to I don’t want the kids to hear me, we need to have a set time, and things like that. I wish	Survivor describes inability to remain engaged in sex longer than 5 minutes; partner is often rushed through the act; expressions of desires to extent the time of sexual engagements	Triggers and challenges that negatively impact intimate occurrences	“Healthy Positive experiences of intimacy; residual effects of abuse present”

I could enjoy it a lot more and it's not him in a sense of, oh he just lacks in that area, it's just I'm short. I don't know if the right word is patience for it. I don't know. I just feel like, "Okay, hurry up," after five minutes, "I want to go to sleep," or "Hurry up the kids," or something. I wish I could enjoy it more in the sense of enjoying the sexual part.			
I was bad at one point where I was like, "Hurry up," and he used to hate it. He hated it. He would just be like, "I'm done. Fine." I didn't like that. I didn't want that because I wanted him to actually enjoy it, I wanted him to be in the moment. If I got enjoyment out of it I wanted him to enjoy it too. He didn't he hated it. I would be like, "Are you done yet?" He would just be like, "You know what, I can't right now."	Survivor's actions of rushing partner through sexual intimacy caused him to give up and loss interest in the intimacy altogether; survivor expresses not liking this process as she wanted partner to also get enjoyment out of their sexual intimacy	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
My intimacy is great with my boyfriend, but he just want to run things with our relationship his way. He want to run things the way he want to run them and I'm just not for. Like he want to tell me when to have	Intimacy is described as great in the relationship by survivor; however, survivor explains that partner wants to control the functioning of the relationship including how sexual	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

sex and how to have sex and I'm not for it.	intimacy occurs between them		
It's like, "Oh let me give babe a kiss today." Like I'm thinking about it and I'm conscious of it. It's not second nature, which I feel it should be. I've never been real forward with it either, but I just feel like as open and as forward as he is to me, I should be able to reciprocate it because I want him to feel like I love him and I want to kiss him and hug him as much as he does me. But I've never been one to be forward.	Survivor explains how intimate interactions with partner do not occur naturally; there is a level of consciousness about engagement in intimate interactions; they are more planned than spontaneous; difficulty with being forward with intimacy is identified as the cause of such behaviors	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I'm so grateful for him because I feel awkward expressing intimacy and he never makes me feel awkward, but I feel awkward. Even with sex, am I doing it wrong or – but he never makes me feel that way. I know with my ex, he used to be like, "Why are you asking for a kiss," and it would always come out with an attitude. But with him if I ask him for a kiss, he'll be like, "Oh sure babe," and give me a kiss. If I be like, "Can I have a hug…" And sometimes it don't sound like the sexiness or it's just like in my moment, "Oh can I	Survivor expresses feeling awkward during engagement in physical and sexual intimacy with partner; partner helps ease awkwardness with patience and letting survivor know he is receptive to her effort	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

have a kiss," and he'll be like, "Sure," and he'll come give me a kiss.			
when he asks me it's like, "Huh," because nobody really asked me what do you want me to do to you, you know? So I'm stumped about that because it was never like that. With my previous relationships it was never about what do you want me to do to you; it was always, "I want this," or "I gotta do this," or "I better get this." It's a little different.	Struggles with identifying and expressing sexual needs/wants to partner; difficulty can be contributed to never being asked about sexual needs/wants in previous relationships; current partner displays interest in learning about survivor's wants and desires	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
He want me to talk dirty to him. Like I don't know how to do that, so it's like, "What!" Like what do I say? And see another part of that is throughout my whole life it was always about pleasing somebody else whether its this relationship or whatever, so for me to say, "Okay, I like to do that," or for somebody to ask me, "What do you want me to do," that's a hard thing for me.	Difficulties with understanding partner's intimate desires and expressing own intimate desires	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
For me, it's just weird. I'm just like, "Okay, well what do I say?" It's so spur of the moment like, "Okay, what do I say?" It's	Partner's actions of checking in with survivor during intimate experiences are defined as weird	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of

just something out of my norm; having someone check in with me it's something that I'm not used to.			abuse present"
So my current relationship we've been together for two years, and we were friends before we decided to be in a relationship. In the beginning, I think with him it started off the same way as with other people. If he would ask for a hug I would be kind of standoffish a little bit. Kissing in public was off for me. I think as I became more comfortable it became better, but I think even still now, when he go to reach for me, I don't think I recoil as much as I did in the beginning, but I still flinch a little bit sometimes. It's not all the time, but if it catches me off guard, if I'm not sure what his intentions are and he just goes to grab me, I'll flinch a little bit.	Survivor describes how comfort with engagement in physical intimacy with partner improves as the relationship grows; individual explains how there are still times when she will flinch or recoil because of discomfort with the acts, but such actions lessen as the relationship continues to build	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

It's definitely not as bad as it was. I'm thinking about how this relationship is going compared to how previous ones have gone. I see progress in this relationship. I'm more comfortable with him, but I know I still feel uncomfortable in certain situations, especially if he doesn't make me aware. Like, "Oh babe, give me a kiss." If he just grabs me or if we're laying still and I'm thinking he's sleep and he reaches over to touch me, I'll recoil a little bit.	Feeling of greater comfort with this partner in comparison to other partners; explanation of how important it is for partner to always make survivor aware of any physical contact; any physical contact that occurs without awareness causes survivor to flinch or recoil	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I've broken down in the middle of sex and told him, "I can't do this," and I just start crying.	Triggers have arisen during sex which has led to survivor breaking down and informing partner of an inability to continue engaging in the act	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I pretty much hold back a lot and I don't believe what the person is saying so it's like you've got to prove it to me. So it still holds me back from just kind of letting go and being comfortable with what I'm doing	Experience of abuse has caused survivor to hold back from letting go and being comfortable with intimacy	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
Sometimes with my partner I can't do certain sexual positions. I didn't know there was so many positions.	Survivor describes an inability to have intercourse in some of sexual positions; the most challenging position is similar in	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of

There's one position, I guess a woman is lying face down and the guy lies down too and you're having regular intercourse from the back.	nature to the positioning of survivor's body during CSA		abuse present"
I really haven't dealt with the sexual part of me being molestated. I know that I had been and I'm aware of it, but I don't know if that is still like a part of me that I need to work	Survivor experiencing residual effects of CSA; unresolved issues cause issues with sexual intimacy	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
		Triggers and challenges that negatively impact intimate occurrences	
we're close, I feel like I know a lot about him, practically everything, but I guess I'm still expecting something of that nature to come like when I was a kid.	While survivor does have a close relationship with partner, fears of experiencing some sort of trauma do linger	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
he doesn't scare me but I don't want to feel like jumpy. I wish I could just be open. I think that's the biggest thing, because he's very affectionate and he made me aware of that from the beginning,	Individual has desires to mirror the level of affection and openness with intimacy that partner displays, but does not have the capability due to past experience; experience of abuse causes survivor to display physical signs of discomfort (jumping when being touched) which reduces ability to receive and provide intimacy	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I think I probably express sexual intimacy	Survivor somewhat non-receptive to	Triggers and challenges that	"Healthy/ Positive

more, than physical. My husband is the feely, touchy one. I like it, it's cool, but I probably won't be the one to initiate it as much	physical intimacy; individual less likely to be the one who initiates physical intimacy in relationship with husband; survivor does like physical intimacy at times, but partner is more likely to initiate touch	negatively impact intimate occurrences	experiences of intimacy; residual effects of abuse present"
in the beginning of our relationship, I would say, I was probably more of, the aggressor, but as we went along the relationship, then I can't really say that I don't know if that's tied to that or not. As we went along in our relationship, i became less aggressive, and that was a little bit of a challenge, because my husband was used to me being the aggressor. and so then when I wasn't, he was like,	Early on in the intimate relationship survivor was the one who would initiate sex and other intimate interactions; as time progressed survivor's nature as the aggressor lessened; survivor desires for husband to become the one who initiates sex	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I get turned off, very easily. But I don't know if it's just me, or women in general. You know, we're mental, they're visual. So, it's like the smallest little thing could like, turn me off. And sometimes I feel like that might be an issue.	Getting turned off easily during intimate interactions is identified as an issue for survivor; uncertainty if this is tied to abuse or just the nature of women	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
Even though...I enjoy the kissing, I enjoy all of that, the foreplay and everything involved. Something I don't think I've ever	Survivor does have good experiences of intimacy with partner; describes how partner performs oral sex on her regularly, but she	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of

expressed to him or told him about is my feelings about me giving him foreplay. I do it because he's my husband and I know he enjoys it, but I think talking about it now, I don't enjoy it. And I think it's because of when my stepfather used to put his penis in my face.	can't do the same because she doesn't like oral sex; when she does it's only for the purposes of pleasing husband; there is discomfort engaging in the act due to flashbacks of the abuse		abuse present"
That's another thing that he knows about the whole porn situation. In the beginning he always had porn and I get bothered if I go through his phone to use something or search something and I see porn sites, that bothers me and he knows that. I told him and he knows now, you don't want me because I'm your wife, you don't want me because I'm beautiful, you want me for these things you want because you want sex and I'm your wife. There is a difference. So if you want me because I'm your wife and I'm such a good woman, then it's you like to watch asses all day long and so that's what makes you want sex. Not that you want me but you watch it.	Survivor described discomfort with partner's desires to view pornography; his actions created feelings of insecurity and remind survivor of the exposure to porn that occurred during experiences of CSA; issue negatively impacted intimacy as survivor loss desires to engage in sexual intimacy with partner	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I think if I wasn't considering his feelings, I would be	Survivor explains how engagement in physical intimacy only	Triggers and challenges that negatively impact	"Healthy/ Positive experiences

okay with never asking for a hug, a kiss, or anything. I don't think it would phase me as much. I mean as long as he's doing it to me – I think I only do it because I know I should	occurs due to partner's desires to engage in the acts; individual would not engage in physical intimacy if partner did not initiate the acts	intimate occurrences	of intimacy; residual effects of abuse present"
I remember just telling him, "I just don't like that position. I can't do it." I don't like that position because it takes me back to my abuse	Flashbacks to experiences of abuse during engagement in intimate acts that resemble the abuse	Triggers and challe that negatively imp intimate occurrence	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
In the beginning it was hard and I thought the relationship wasn't going to last because I thought he was going to get sick of me not wanting to be hugged and kissed and touched.	Difficulty in the beginning of current relationship due to discomfort with both forms of intimacy. Identification of physical intimacy as more difficult to experience	Triggers and challenges that negatively impact intimate occurrences	Fragmented early sexual experiences and intimacy following CSA
I'm definitely disappointed that I'm not as open to receiving any kind of affection how I would want to be.	There is a desire to receive affection from partner, but disappointment in the inability to openly receive it	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I wish I could just get out of that uncomfortable stage and just go ahead and receive it. Shoot if I want sex, I should be able to initiate it.	A desire to get out of the stage of discomfort with intimacy and open up to fully receiving it/initiating it	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
That was in the past, but now it's like I know that it's okay so it's better for me to be physical with somebody, to hug somebody. Like I find	Progression is being made with ability to engage in physical intimacy as survivor is learning that physical intimacy is ok, but it is occurring in stages	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of

myself hugging a lot of people now. Hugging people, kissing is still kind of iffy. I will kiss, but just that physical touch or just touching somebody I'm getting better with that now that I know that physical touch is okay; whether it's sexual or not, it is okay.	(i.e. hugging then kissing)		abuse present"
As far as the physical, there's nothing wrong with that. Actually, I like that better than anything. I learned thats one of my love languages- physical touch. Since I know that's my love language I can do that all day, just talk each other, just laugh, kiss here and there or whatever the case may be. I actually enjoy that a little more than sex. Now I like sex too, but it's more of the closeness of getting to know that person when you are intimate without sex. I think it's better to get to know a person that way first, because you know sex complicates everything.	Survivor educated herself about intimacy and developed an understanding of what type of intimacy feels the best and why	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
As far as sexual intimacy, I would say I'm great to some extent. There were times when there was, again like a trigger from the times when I walked through abuse	At times survivor did become triggered during sexual intimacy; individual had to learn about positive sex in adulthood which	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

in childhood but as an adult I had to actually learn about sex. Like forget everything that I knew about it and learn all about the sex energy or sex itself in order to accept it as a part of my adult life or as something that would be – well I guess to say that pleasure was okay. That it's nothing wrong with pleasure as long as it's something that you decide you want for yourself and you have a consenting partner.	involved forgetting past abuse;		
So today, I feel like things are in a really good place so I wouldn't really change anything today. I think from studying and from really getting more into myself and learning more about sex and energy itself – because it's not just physical sex; it's energy. It's very creative.	Education about self and sex has led to comfort with intimacy	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
separating sex from the abuse and recognizing that abuse of sex can stain your idea of sex itself and cause you to not use that energy to benefit you.	Developing an understanding that abuse that involved sexual contact can lead to distorted thoughts and feelings about sex itself	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
It's different now, of course, because now I just welcome love and I welcome the expression of love. I wouldn't say that I'm	Things are currently different with intimacy and love/expressions of love are welcomed	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of

1,000% there, but I will say 999%.			abuse present"
Now I'm more me and I don't have to hide the part of myself that I felt was abused. I can now allow that to come out and not be afraid that I'll get hurt or that it can go to a place where I don't want it to go; violet or… Yeah, it's no longer a hindrance, I want to say.	Prior to current place in life some intimate expressions were hidden out of fear of potential hurt or returning to an undesired place; currently, intimate expressions are not hidden making the abuse no longer feel like a hindrance to intimacy	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
She's facing down during sex. That's a very – because that's when a woman lifts her butt up. That for me is a very hard position. I remember telling my therapist, "How am I supposed to be able to do that and feel comfortable?" She said, "At the moment, if you feel as though you might be going back to that incident, open your eyes and look who you're with." For a while that's what I was doing. Look around and remember you're in a safe spot.	Survivor receives tips from therapist on how to put self at ease during sex which would allow for an ability to engage in difficult sexual positions; individual explains how the tips worked for a while, but difficulties with positioning during sex still arise	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I'm learning to just, I guess, enjoy the act, instead of what my past was. It was fearful, it was uncomfortable, it was violating..it was, um, I didn't like it, so now being married, where I am comfortable, where I'm	Survivor is learning to enjoy the act of sex after the trauma of sexual abuse experienced in childhood; sex during abuse was uncomfortable, fearful, and violating; sex in context of	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

safe, where I am loved, it's that part..its foreign to me. And I'm learning to adjust to it	partnership described as safe and loving		
now being married, where I am comfortable, where I'm safe, where I am loved, it's that part...its foreign to me. And I'm learning to adjust to it	Intimacy in the context of a loving marriage described as comfortable and safe, but it's foreign and survivor is learning to adjust to them after experiences of abuse	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
also letting go and just trusting him, and that's when it came into play that I had to trust him, to carry on a healthy sexual relationship with him, physical, and spiritual. I just had to trust him. Not trust him to make the right decisions but trust him that he would not hurt me.	Process of establishing trust in partnership was a key factor in developing a healthy sexual and physical relationship; survivor had to develop trust that partner would not exposure her to the same hurt that was experienced in childhood	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I had to learn to love him and give him that attention, affection, and things like that and to pay attention to those needs. Now it's gotten to a point when he voices his issues, I actually apply it. I listen and I apply those things.	After difficulties with intimacy in partnership, survivor had to learn how to love partner and give him the affection and attention that he expressed	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
Before I told him about the abuse there was a lot of feuding. After I told him there was a lot of negotiating and making – I don't want to say deals, but making sure the other person was satisfied and it wasn't all about	Prior to disclosure of abuse to partner there was a lot of feuding surrounding the intimacy; after disclosure, survivor and partner were able to come to a mutual understanding on how	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

them during intimate moments.	to better the intimacy in the relationship		
The person that I'm with now, he is very well studied, so this is how I was able to study. He and I were more intimate than I've ever been with anyone else. It was almost like I was finally at a place where I was ready to just be myself, in many ways from physical intimacy to sexual intimacy to just my personality overall.	Partner's characteristics create comfort for survivor; as a result intimacy in partnership is more positive than past experiences and survivor feels as level of comfort with engaging in both sexual and physical intimacy	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
In a better way. In a way where I'm mindful of his feelings, I'm definitely mindful of my own. I don't do anything I'm not willingly ready to participate in doing. I have to actually want to do whatever it is we're going to do sexually or anything. So in a good way. It makes me not take things for granted	Experience of abuse has assisted with being mindful of partner's and own feeling during intimate moments; survivor is mindful about boundaries and limits and doesn't engage in any acts if the desire is not present	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
Because of my awareness, I'm able to be more passionate, more considerate. I'm not a pushover. I still make it clear what I like and what I enjoy. At the same time, I'm open to knowing what he likes and what he enjoys. It's about us, it's not just about me or just about him, it's about us	Survivor explains how awareness (of ways in which abuse impacts intimacy) has helped with expressions and receptiveness of intimacy; an ability to identify desires and be receptive to partner's desires has allowed for unified experiences of intimacy	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

I think, sexual, um, again would be hard again, I don't have flashbacks, I just think, I, I'm just, it's an everyday, it's still an everyday process, in a sense.	Even in the context of a secure intimate relationship, survivor describes how it's a challenge enduring intimacy (sexual) due too past	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
In the past I feel like my abuse has impacted intimacy in my relationships, but I don't think about it no more. So, I don't think it has an impact now. In the past I couldn't deal with having sex with men I was with. Everytime we would start I would break down.	Believes abuse has impacted intimate experiences in the past, but it has no impact on intimacy in present relationship; in the past sexual intimacy would trigger recollections of the past causing the entire experience to be negatively impacted	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I've learned that it's a journey, and that undergoing years of sexual abuse, um by people, that I trusted, and I don't expect it for me to be like 100% OK in the area of sexual intimacy.	Expectation that there will never be 100% comfort with the intimate experiences that are similar in nature to the endured abuse	Process of learning to experience positive intimacy after abuse	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I would just be more open to his affection. You know I watch movies where guys just grab their girlfriends and just give them a big sloppy kiss or something like that. I just want to be able to feel normal and – he doesn't scare me but I don't want to feel like jumpy. I wish I could just be open. I think that's the biggest thing, because he's very	Feeling that experiences of intimacy are not normal; desires to have intimate experiences that are not clouded with fear and nervousness about intimacy	Triggers and challenges that negatively impact intimate occurrences	Healthy/ Positive experiences of intimacy; residual effects of abuse present"

affectionate and he made me aware of that from the beginning, so I wish I could just…			
There are sometimes when I'm like, "Oh babe, give me a kiss." But if we're like lying in bed and I want to have sex, I don't feel comfortable initiating it. I wish I could be a little bit more forward with it	Desires to be more forward with sexual intimacy, but discomfort with initiating the acts	Triggers and challenges that negatively impact intimate occurrences	Healthy/ Positive experiences of intimacy; residual effects of abuse present"
Like I said, I've always been – and for the same reasons, I've never been an initiator. I didn't have sex until I was 18, but I didn't kiss a boy until I was 17, because in my mind it was always, "Am I doing it wrong? Is he going to think I look stupid?" I don't know, I just always thought that that was the type of person I was. I'm just a scary person.	Self-consciousness about initiating intimacy with partner due to fear of improperly engaging in the act or being perceived as stupid	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I think I can lie in bed and be like, "Damn I want to have sex." He can be sleep and he don't know I want to have sex because he's sleep and I'm like, "Okay, I'm going to do this to wake him up or arouse him," and then I will really lie in bed and think about it and it will never get done. Then I'll be like, "Alright, I'm going to do it after this or I'm	Survivor expresses discomfort with initiating sex with partner; individual has the desire to engage in sex with partner and tries to build up the courage to initiate sex, but isn't able to follow through with the act	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

going to turn over and do it, and I never had the nerve to do it and it just never gets done. I just feel uncomfortable like I'm going to do it wrong. I don't know why but that's what goes through my mind if I want to have sex.			
Um, I'm kind of disappointed in myself sometimes when my boyfriend he goes to touch me, hug me, any kind of intimacy and I back away from it because I feel like right now I should be past this. I do trust him. I trust him with me life. I trust him with my son and I feel like it shouldn't bother me this much and I am disappointed in myself that I can't receive it. There are sometimes when I'm like, "Oh babe, give me a kiss." But if we're like lying in bed and I want to have sex, I don't feel comfortable initiating it. I wish I could be a little bit more forward with it and I'm definitely disappointed that I'm not as open to receiving any kind of affection how I would want to be. I feel like with this person I should be able to because he has given me no reason not to.	Survivor expresses frustration and disappoint in self for still allowing abuse to impact experiences of intimacy. Individual expresses desires to be more open to receiving affection and initiating intimacy, but lacks this ability due to struggles with being touched.	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

He has been supportive and patient throughout our whole relationship. I wish I could just get out of that uncomfortable stage and just go ahead and receive it. Shoot if I want sex, I should be able to initiate it.			
Because he's told me that he doesn't feel wanted because he feels like he's the one who is always initiating sex and he's like, "I feel like you can do without it." I'm like, "Honestly yeah, because I've had alot of sex in my day.	Survivor explains how lack of desire to initiate sex has left partner feeling unwanted; issues with initiating sex stem back to promiscuous behavior that occurred after abuse	Triggers and challenges that negatively impact intimate occurrences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"
I began to trust him when I let everything go. I never had a problem with him touching me a certain why... like that never affected me	Survivor expressed having issues with establishing trust within partnership after enduring CSA, but never had an issue with intimacy	Abuse has no impact on intimate experiences	"Healthy/ Positive experiences of intimacy; residual effects of abuse present"

APPENDIX H: Exhaustive Narrative

An experience of childhood sexual abuse (CSA) can negatively impact how African American women experience intimacy in adulthood. The impact of this abuse may look different for each woman, but issues with physical and sexual functioning occur for many. Three common issues following CSA are promiscuity, discomfort/fear of intimacy, and avoidance of intimacy. It is important to note, not all women with a past of CSA encounter such issues nor are they impacted in the same way.

Promiscuity, Avoidance, and Discomfort/Fear

Some women display promiscuity (e.g. sex with multiple partners, sexual activity with older men, and sex at a young age) in late adolescent and early adulthood after CSA. Reflections on promiscuous behavior from a few women explain the behavior and underlining causes of it. The desire to feel loved led to promiscuity for one women,

> "It affected me before him before I let older men touch me because I felt like they liked me or they accepted me or they loved me or something like that because they put their hands on me or they touched me in this way, so I felt loved. So that's how it affected me like with teenage relationships. I mean I was 16 dealing with a 29-year-old man."

The belief that love was being gained from men led to promiscuity for this women, it was the control gained from the behavior for another,

> "I would see men and I would just go for it. It was the attention from men which was very, very controlling for me. It was like, "I got to have that. I need to know that you like me, I need to know that I'm attractive."

Low self-esteem is another contributor to promiscuity for some women who have endured CSA, “I think that was a part of me being insecure and me having low self-esteem thinking I’m not good enough for somebody so I would just do it just to do it and not really be attached.” All in all main contributors to promiscuity are low self-esteem and desires to feel attractive, be liked/ loved by men, and be in control.

The desire to have a close connection with a male leads to inappropriate touch and sexual activity. There is an emotional detachment from the behavior making the interactions easier to experience. As a result of the detachment, some experiences cannot be recalled. The past traumatic experience (s) also causes a lack of self-respect and the inability to see one’s true self-worth. However, promiscuity also offers a level of completion and satisfaction given the extreme amount of distress caused by CSA.

In comparison to promiscuity, avoidance of intimacy is the opposite response. Avoidance of intimacy often starts immediately after the abuse with the elimination of touch from everyone, including non-perpetrators. In the words of a woman who experienced harmful touch, “After the abuse everybody was just cut off with hugs and I didn’t hug nobody.” Intimate interactions similar in nature to actions that occurred during the abuse are avoided the most. For example, it is likely women who experience inappropriate sexual activity will avoid sex with a significant other,

“I guess what happened to me more frequently, was you know, is the sexual part. So, yeah I think that's why I'm less, receptive in that area …. I guess it was, I guess experiencing growing up, a lot of flashbacks, so, um, and I just always, thought, it always just felt like it was being repeated.”

Women who avoid intimacy often have a late on-set of sexual behavior. Even after the initiation of physical and sexual intimacy, some intimate exchanges are still avoided.

Avoidance of intimacy causes difficulty with sustaining a relationship for a long period of time. The struggle with being open about the abuse and distress that follows cause some women to push partners away and avoid intimacy with them. This issue ultimately creates a divide between partners and the relationship falls apart. One woman described this process during reflection of her past marriage, "My ex-husband and I are now friends and we discussed the past. I explained to him some of the moments where I just couldn't bear to be intimate with him and we actually went over why. It was very healing to revisit that past relationship because that was one that I really took to heart and when things didn't work out, I would say that was the start of the process of me trying to figure out what is going on with me that I can't really open up to somebody that I love or that I can push this person away." This story shows the battle between the desire to enjoy a romantic relationship and unresolved trauma.

Those women who do not avoid intimacy or engage in promiscuous behavior are able to experience some form of intimacy with male partners. In fact, most women can engage in some form of physical and sexual intimacy within a monogamous relationship after CSA. However, some intimate experiences are feared or described as uncomfortable. Again, intimate interactions that are reminders of the past abuse are the most feared and uncomfortable. There is always a preference for intimate interactions that do not lead to reminders of the past. Both preferred and non-preferred forms of intimacy can cause nervousness because there is an inability to relax and fully engage with partners. At times the nervousness rises to a level of extreme emotional distress

causing a breakdown which can occur during an intimate moment. This was the experience of a woman who underwent several breakdowns during intimacy, “In the past, I couldn't deal with being touched in like an intimate way. Every time it would start I would break down.” Discomfort and fear of intimacy have severe consequences for romantic relationships. Potential consequences include an inability to engage in intimacy for prolonged periods of time, beliefs that something is wrong with intimacy (e.g. hugs and kisses) and fear of attachment. If one’s partner is unable to accept the inconsistency with intimacy, it is unlikely that the relationship with last. In time comfort with intimacy does get better for some individuals, but it is believed 100% comfort with intimacy may never occur.

Promiscuity, avoidance, and fear/discomfort with intimacy are not the only adverse reactions to CSA. Other issues connected to unresolved trauma include insecurity, emotional turmoil surrounding intimacy, poor boundaries, self-blame, and a lack of desire for intimacy. The difficulty with maintaining a relationship causes self-blame for some women. These women blame themselves for the downfall of their relationships without considering how unresolved sexual trauma causes barriers with partners. To avoid the possibility of further exposure to trauma, walls are often built as a form of protection. The downfall of this action is the blocking of physical and emotional connections with partners which cause relational instability and distance. Relational failure becomes unavoidable due to the issues with intimacy and other factors that persistent. This inability to maintain a relationship can lead to self-blame and eventually a negative view of self. Even in cases where other factors have contributed to the failure of the relationship (e.g. infidelity) there is still a blaming of self.

Another issue that leads to a negative view of self is equating love with sex. This issue stems from the belief that sex must be present in order for love to exist. Women with this mindset hold themselves solely responsible for maintaining a relationship and perceived issues lead to a negative view of self,

> "I used to think, "Well that means you're not attracted to me, I'm not beautiful in your eyes, you don't care for me, and you don't love me. My ex-husband told me, "It's not that, I will always love you. You're always #1 in my heart. I want you to start to understand that if a person doesn't touch you or doesn't make you feel sexually satisfied it does not mean they don't love you. It doesn't not mean you're not special to them, they just might not be feeling like that at the time."

Experiencing broken boundaries in childhood creates trouble with implementing healthy boundaries in adulthood. An example would be constantly breaking promises about abstaining from sex with male counter parts. The result of such behavior is an out pouring of emotional turmoil due to beliefs that the body is freely being given way to men. There are also concerns about the future of the relationship given sex occurred without the establishment of a solid relational foundation with the male.

Intimacy, Sexual Abuse, and Current Partnerships

It may seem as though all physical and sexual experiences of intimacy are troublesome after CSA, but positive experiences of intimacy are possible. In time, dysfunctional intimate interactions begin to decrease and healthy experiences emerge. Many women describe intimacy within their current relationship as physically and emotionally healthy. Issues that may arise are not outside of the relational norm. Some

contributing factors to positive intimate experiences are comfort and safety with intimacy, a solid relational foundation, openness about intimate interactions, partner satisfaction, and similar views on intimacy.

Statements from women discussing intimacy in their current relationship reflect positivity. Examples of such statements are, "I'm comfortable touching, kissing, hugging, lovemaking, and sex, of course. I feel like we both are on the same accord when it comes to our physical and sexual relationship;" "Just the kissing, the hugging, the rubbing and everything. Everything he does help make intimacy better for me;" "We hug a lot, we touch each other a lot, it's more intimacy than I ever really had in my previous relationships;" "I'm very comfortable with the intimacy in my marriage. The comfort level is a 10; 10 being good." Contentment with intimacy leads to regular sex and enjoyment with receiving/giving physical and sexual intimacy. Unlike past occurrences with males, intimacy occurs without difficulty. There is still a preference for the form of intimacy that is least likely to trigger reminders of the past, but engagement is possible.

Even within the context of a loving partnership, challenges with intimacy are still present for women with a past of CSA. While intimacy is described in a positive light, residual effects of the abuse cause undesired experiences from time to time. A few issues that arise are inability to remain engaged in sex for prolonged periods of time, rushing through periods of intimacy, quickly losing interest in intimacy, a lack of intimate spontaneity, difficulty with being forward about needs, feelings of awkwardness during sex, struggles with understanding partner's needs, and an inability to show affection and openness. It is possible that a variety of other factors could be contributing to these challenges (e.g. lack of interest in sex could be the experience of women in general), but

enduring CSA is definitely related. The leading cause of ongoing challenges with intimacy is encountering situations that lead to triggers. Anything (e.g. a sexual position) can trigger a flashback inhibiting intimacy. A husband's desire to view pornography repeatedly triggered flashbacks of molestation for one woman causing distress. In this case the spouse's actions not only caused feelings of insecurity, but they also repeatedly returned the women to experiences she is trying to forget.

Overcoming the past and moving into a place of satisfaction with physical and sexual intimacy is a process, but it is not impossible. The unwanted touch and sexual interactions endured in childhood may have led to dysfunction in relationships, but feelings of security and safety with a partner make acceptance of intimacy a possibility. Interactions once perceived as uncomfortable, fearful, and violating become welcomed as time passes. Obtaining education on the differences between harmful vs. non-harmful sex and touch and trust all help reshape views and build comfort with intimacy.

The first step in becoming educated is coming to understand that sexual abuse can lead to distorted thoughts and feelings about sex itself. Awareness has to be gained about the difference between harmful vs. non-harmful sex and touch. This awareness creates mindfulness about boundaries and limits which can improve expressions and receptiveness to intimacy. The next step would be learning about intimacy itself. This includes learning the specifics about intimacy and understanding which types of intimacy feel the best and why. This helps replace negative views of sex and touch with more positive ones. Women who have endured CSA understand flashbacks to the past are likely during this time of education as such occurrences are a part of the process of change. Therapeutic work is also a good avenue for education. A therapist, for example,

can give tips on how to become at ease during difficult sexual positions. Even though therapeutic tools may be helpful, some may not find them to be effective all the time.

Learning to trust may be the biggest contributor to desires for transforming thoughts about sex and touch. This process involves understanding that intimacy within a partnership would not be possible if trust is absent. As explained by one women, "Letting go and just trusting him, and that's when it came into play that I had to trust him, to carry on a healthy sexual relationship with him, physical, and spiritual. I just had to trust him. Not trust him to make the right decisions but trust him that he would not hurt me." Tied into trust is learning how to love a partner, give him the affection and attention he desires, and come to a mutual understanding with him on how to better intimacy in the relationship.

The end result of all education is no longer hiding intimate expressions out of fear, potential hurt, or returning to an undesired place. Shifting perspectives about sex and physical contact is an adjustment. It may seem foreign, but feelings of safety and comfort with the current partner help to ease things. As the wounds of the past start to heal, issues preventing intimacy began to lessen which is a time of excitement for some women. Per one woman "Now I just welcome love and I welcome the expression of love. I wouldn't say that I'm 1,000% there, but I will say 999%!"

Partner Awareness

There are often several issues in a partnership (e.g. feuding surrounding intimacy) prior to disclosure of abuse. However, disclosure tends to spark changes in how partners relate to each other. Some believe partners become more understanding after they learn

the truth about the abuse. Disclosure may include specifics about the abuse and ways a partner can offer support which helps improve and booster intimacy.

Openness and honesty between partners allows for exploration into how the abuse impacts relational functioning and how to address it. After learning about the abuse and how it impacts physical and sexual intimacy, women believe their partner's approach to intimacy changes. This change includes becoming more understanding and patient during intimate exchanges to ensure there is a feeling of safety in the relationship. There is a validation of struggles with intimacy and acknowledgement that the past can still negatively impact the present. For example, partners come to understand that a flashback may trigger a negative response. This does not mean the partner has awareness of everything that can lead to a trigger because at times the behaviors of the partner may become a problem causing a slight rift between partners. This issue can be resolved with open dialogue and clarity about what caused the problem. Patience is exhibited through addressing any difficulties that arise and accepting that sex and intimate touch may not always occur in the relationship.

A supportive and nurturing environment helps intimacy blossom in a relationship plagued by a past of abuse. Partners create this kind of environment for women by encouraging awareness of the present and not the past, showing affection, doing different things to help bolster confidence and learning intimacy desires (e.g. provides hugs and kisses to help transition into sexual intimacy). Intimacy is allowed to naturally unfold between partners and pressure to engage in intimacy is never applied.

No impact on intimacy

There are a lot of women who experience intimate and relational challenges after CSA, but this is not the case for all women. Some women do not experience any relational dysfunction in adulthood. In such cases, there is comfort with intimacy and issues are not present. It is possible issues may have been present in previous relationships, but they are absent from the current one. Women who feel unaffected by their past continue to report no issues with partners. Even with after disclosure of abuse to their partner.

APPENDIX I: Essence of The Experience

Most African American women who have endured childhood sexual abuse (CSA) believe their past negatively influences their intimate experiences in some way. Issues often appear a few years after CSA during late adolescent and early adulthood. The ways in which CSA disrupts intimate experiences during this timeframe varies depending on the individual. For example, some women abstain from physical and/or sexual intimacy and others engage in promiscuous behavior with men. The majority of woman can engage in physical and/or sexual intimacy with a partner, but they experience an abundance of discomfort and difficulty with intimate interactions.

Sexual preference: older men & promiscuity

Promiscuity

Promiscuity is most prominent during adolescent and early adulthood. This behavior consists of having multiple sexual partners, sex at a young age, and sexual encounters with men who are significantly older. The culmination of insecurity and desires to feel loved cause this need to engage in meaningless behavior that is void of intimacy. Additionally, a lack of support and guidance with the process of overcoming the tragedy of CSA leads to this behavior. This behavior adds another layer of trauma and may cause more harm than good, but it creates feelings of love and acceptance in the moment for some women.

The experience of sexual abuse can lead one to feel that they have lost control over their body. Defeated, promiscuity helps some regain the control perceived to be lost during CSA. Sex is used in the same manner it was used in childhood: to have power and

control over the gender that caused that caused the pain of CSA. Thus, promiscuity is used to help re-build confidence and self-esteem. This risky sexual behavior confirms the linkage between CSA and promiscuity and demonstrates the sexual dysfunction women face as a result of CSA.

Discomfort/Fear

Most women describe fear and discomfort with intimacy after CSA. The greatest difficulty and discomfort happens with intimate interactions similar in nature to behaviors endured during CSA. For example, CSA that involved penetration most likely leads to issues with sex. The fear of reliving the abuse or experiencing flashbacks/triggers is the shared concern of women who encounter issues with intimacy. The height of discomfort or fear often occurs before disclosure of the abuse. After disclosure of abuse, comfort with intimacy rises and engagement in some intimate behaviors is possible. Despite the ability to participate in intimacy, encounters may be still unhealthy. In particular, intimate expressions that remind of the unwanted interactions that occurred during CSA are feared. There is the ability to partake in intimacy, but exchanges that are even remotely similar to those experienced during the abuse cause fear. Engagement in such behaviors awakens the abused child and causes flashbacks to the past. Even though engagement in intimacy to some extent is possible, fear of returning to that scary, traumatizing period of life looms over women.

A fear of attachment can contribute to discomfort with intimacy. Exposure to CSA breaks trust and attachment with the perpetrator and a lack of repair cause women to enter relationships with their guard high. The outcome is a detachment from intimate partners as a form of protection. Beliefs that intimacy is somehow wrong also caused

detachment. This belief stems from a not separating consensual from non-consensual behavior. After CSA, women make significant attempts to incorporate intimacy into their relationships. Even though some experiences are traumatic reminders of the past, some women struggle through things resulting in discomfort and fear of intimacy. It is possible the yearning to feel some sense of normalcy with intimacy (in the context of a romantic relationship) is the underlining cause of these actions.

Avoidance of intimacy similar in nature to CSA

While some women struggle through intimate engagements, others cannot even bear to engage in intimacy within their relationships. Extreme difficulty with intimacy often results in the termination of relationships. Women enter relationships with goals of longevity, but unresolved trauma prevents them from engaging in intimacy. Intimate experiences may be occurring within the context of a mutual and loving relationship, but a lack of reframing thoughts about intimacy makes encounters challenging. Overcome with fear, some women choose to isolate themselves from others, especially partners. Again, behaviors are a form of protection against possible harm. Even women who have chosen to enter marriages can become so overwhelmed with physical and/or sexual intimacy that they end their marriage. In the end, a lack of openness about the struggles with intimacy leads to the downfall of several intimate relationships.

Adversity caused by CSA

In addition to struggles with promiscuity, avoidance, and discomfort with intimacy, some women encounter other relational obstacles that are directly related to their experience of CSA. These obstacles lead to personal and interpersonal conflict (s) that is not always resolved in an ideal manner. Some of the issues that can arise are

insecurity, emotional turmoil surrounding intimacy, poor boundaries, self-blame, and a lack of desire for intimacy.

Self-blame involves blaming one's self for the downfall of a relationship. In the cycle of self-blame, women do not give themselves permission to endure the adverse effects of CSA. Women who engage in such behavior essentially punish themselves for reacting to the harmful crime of CSA that was committed against them.

Struggles with setting boundaries surrounding sex in relationships is also an adverse reaction. This includes setting limits around desired engagement in intimacy, but breaking this limits and going beyond them (e.g. having sex after firmly stating sex would not occur). The aftermath is always an outpouring of emotional turmoil. It is possible the inability set limits is related to an unfulfilled desire for love and affection. The desire for love and affection may have been fulfilled in the moment with sex, but coming to realize intercourse with the male was nothing more than sex leads to the emotional breakdown.

The struggle with understanding the proper relationship between sex and love is also an issue. Some women equate sex and physical touch with a partners' level of love. Whenever physical and sexual contact is absent, the individual creates negative meanings of one's self. Women who experience this trouble do not understand that love can be present in the momentary absence of physical and sexual intimacy.

To the world, issues such as those described above are typical issues. However, women with a past of CSA that encounter such issues experience an extraordinary amount of distress. The experiences of these women reflect a CSA survivor's struggle with overcoming adversity related to intimate functioning.

Healthy/Positive experiences of intimacy; residual effects of abuse present

Overall, most women describe intimacy in their current relationship as healthy. They explain how partners' interactions and communication surrounding intimacy help them enjoy gratifying and positive experiences. In addition, women describe sexual and physical intimacy as better in their current partnerships even with the presence of ongoing challenges. The challenges these women encounter with intimacy are outside of the norm in that they are connected to their ongoing recovery from CSA.

Triggers and challenges that negatively impact intimate occurrences

Most women who have experienced CSA describe intimacy in their current relationship as good, but approximately 80% state their past of abuse continues to negatively impact intimate functioning within their relationship. Ongoing experiences of flashbacks are the main contributors to the issues that arise with intimacy. While the intensity and frequency of these issues lessen as the relationship matures, problems are still present. For example, physical and sexual intimacy in a marriage may be described as good, but sexual intimacy may continue to be a struggle even though the intensity decreases with the passing of time.

Comfort and feelings of safety with a partner allow women to become more accepting and tolerant of intimacy. Despite the progression with recovery, flashbacks of the past continue to inhibit the ability to engage in some forms of intimacy. As with past relationships, intimate interactions similar in nature to those that occurred during their abuse are most challenging. Engagement in these intimate actions triggers reminders leading to anxiety and fear, instead of enjoyment and pleasure.

Not all women report triggers or flashbacks that inhibit or affect intimacy with current partners, but some do identify issues with trust and vocalization of intimate needs. This is evidenced by finding one's self at a loss of words when a partner asks about intimate needs and desires. This inquiry is a new experience in that these women have never felt like they had say in how intimacy unfolds in their previous relationships. Past relationships have left women with the belief that they do not have a say in their intimate engagements. It is likely that this mindset also stems from the experience of CSA when voices were silenced. The present partner has an interest in intimate desires, but the extensive history of silence causes discomfort with an open dialogue about this matter.

Process of learning to experience positive intimacy after abuse

As previously stated, woman continue to battle with the negative effects of CSA even within their current relationship. Despite this ongoing battle, many are actively working to overcome their issues. The barriers to intimacy vary depending on the individual, but fulfillment and comfort with intimacy are the goals for everyone.

A fear of sex is one barrier. Now that the sexual abuse has ended, learning to enjoy the act of sex is the goal. The process of learning to enjoy sex involves reframing thoughts about sex to associate it with pleasure instead of pain. Any feelings of violation and discomfort are being striped and being replaced with feelings of safety and love. In order to feel safe and loved, trust has to be present in the relationship. The absence of trust is hazardous for a relationship. In order to establish a healthy intimate relationship one has to overcome the inability to trust. Women who battle with trusting have to move past the fear of reliving the trauma and trust that her partner will not re-expose them to harm. The emotional, psychological, and sexual harm caused by CSA put women in a

constant state of fear. To maintain a happy partnership, women have to develop trust in their partners. They have to learn the potential of re-exposure is less likely to happen. The intimacy in a relationship can begin to blossom once trust is gained in a partner.

A lack of attentiveness to personal and intimate needs can also be a barrier. During and after the experience of CSA, some women put the needs of others before their own. In intimate relationships with men, desires and needs are neglected which result in dissatisfaction with intimacy. On the path to recovery from CSA, women have to learn the importance of being mindful of their feelings and needs surrounding intimacy. This involves being aware of individual boundaries/limits and understanding how they resemble and/or differ from those of a partner.

Women continue to encounter issues that negatively affect them individually and relationally. However, daily attentiveness and cognitive restructuring can assist with turning the negatives into positives. Achievement of this shift is largely the work of the individual, but support from an intimate partner is a huge contributing factor.

Positive experiences of intimacy

Many women with a past of CSA describe their current experiences of intimacy in a positive light. Physical and sexual encounters are described as truly intimate given they are shared, desired, and welcomed which is different from experiences in past relationships. The most noted contributors to positivity are feelings of comfort and safety with intimacy.

After sexual violation in childhood, women are taking steps toward becoming accepting and comfortable with intimacy. Their ability to be emotionally open is a change from the past. Women feel safe enough in their current partnership to open

communicate about the dynamics of intimacy, which leads to a strong sense of comfort. The feelings of safety in turn lead to the ability to be and welcoming of positive intimacy moments. A baseline of safety and comfort give women the courage to replace their fear of intimacy with openness and acceptance.

Partner's knowledge has helped create positive experiences of intimacy

Women do feel as though their partner's knowledge of the CSA affects their intimate experiences. They believe their partners' actions and reactions to the knowledge of the abuse helps them become more accepting of intimacy. Things such as support, patience, comfort, and awareness are ways partners are assisting with/ enhancing and embracing of intimacy.

Understanding/Patience

The most impactful actions of partners' are patience and a level of understanding. Instead of becoming angry and intolerant, partners show patience and acceptance. Even if the partner does experience frustration with how intimacy occurs at some points, he is able to overcome these issues and continue to be supportive. The ability to be understanding and sympathetic sets the tone for the relationship and assist women with becoming more open and welcoming of intimacy.

Intimate interactions with partners can be rough in the beginning due to ambiguity surrounding some actions. An example would be a partner's inability to understand why sex cannot occur in some positions. After gaining insight into the issues, the partner's perceptions of intimate engagements change. A lack of awareness of the abuse leaves partners with more confusion than answers creating frustration. Before disclosure, partners are unable to see eye to eye on intimacy. Partners are able to resolve their issues

once both individuals discuss past events and how to move forward given the challenges caused by the CSA. The identification and implementation of boundaries helps to improve the quality of intimacy in relationships. In addition, partner's respect and acceptance of these limits is meaningful and impactful to the relationship as a whole.

Creation of a Supportive Environment

In addition to being patient and understanding, partners create a supportive environment for the partnership. A few of the things that create this supportive environment are not forcing intimacy, attentiveness to warning signs, open dialogue about intimacy, and assistance with building confidence/self-esteem. These things promote partner awareness of the residual effects of CSA and support for the recovery from this trauma.

An important aspect of intimacy following an experience of CSA is having one's voice heard surrounding intimacy. Intimate interactions that are not forced or demanded are more likely to be welcomed because intimacy is viewed as a choice instead of an obligation. When males learn the needs and desires of their partners who have been victimized, they can adapt to their intimate style. This discussion of intimacy beforehand services two purposes for Maria: it shows respect for her level of comfort with intimacy and lets her know that she has the control over her body.

Open dialogue between partners also creates a supportive environment. An example would be discussing intimacy before it actually takes place. This type of discussion services two purposes: it shows respect for the woman's level of comfort with intimacy and lets her know that she has the control over her body.

A keen awareness of triggers helps with the development of a supportive environment. A partner's ability to be aware and consoling during uncomfortable moments helps with overcoming problems that create issues. The response of the partner gives the support and courage necessary to continue the process of recovering from CSA. Partners' responses also make recovery the couple's responsibility and not just the victimized.

The vast majority of the women who experienced CSA have similar experiences with intimacy from past to present. All of these individuals: a) feel an experience of CSA does have an adverse impact on intimate experiences, b) identify intimacy in their relationship as positive even with their past, c) acknowledge that CSA continues to create issues with intimacy, and d) believe their partner is supportive of their struggles with intimacy and assists them with overcoming the trauma. However, some women may feel as though their experience of CSA has not influenced their past or present intimate experiences. Others may feel adversity is not present in their current relationship, but issues were present in past relationships.

Almost all women who have endured CSA have had an extremely rough start with intimacy in romantic relationships. In early relationships, women are either promiscuous, avoidant, or unable to maintain healthy intimacy due to ongoing difficulty with intimate interactions. These challenges with intimacy ultimately lead to the demise of relationships. As women began to address their trauma and understand how their past manifests itself in every facet of their life, involvement in a positive, intimate relationship becomes possible for them. A partner's sensitivity to the residual effects of CSA makes openness and receptiveness to intimacy a possibility. Even though recovery from CSA

continues in the present for women, partners show a willingness to walk through this process with them.

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Drexel University, Feb. 2017	**PhD**
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CLINICAL EXPERIENCE

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